MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-first Session
March 24, 2021

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:00 a.m. on Wednesday, March 24, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Dina Neal, Vice Chair
Senator Melanie Scheible
Senator Roberta Lange
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Keith F. Pickard

GUEST LEGISLATORS PRESENT:

Senator Nicole J. Cannizzaro, Senatorial District No. 6
Senator Julia Ratti, Senatorial District No. 13

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Sandra Koch, M.D., Nevada State Medical Association; American College of Obstetricians and Gynecologists
Ann Silver, CEO, Reno + Sparks Chamber of Commerce
Christine Saunders, Progressive Leadership Alliance of Nevada
Elizabeth Davenport, American Civil Liberties Union Nevada
Victoria Ruiz-Marin, Planned Parenthood Votes Nevada
Serena Evans, Nevada Coalition to End Domestic and Sexual Violence
Caroline Mello Roberson, NARAL Pro-Choice Nevada
Marcos Lopez, Americans for Prosperity Nevada

Ken Kunke, PharmD, Nevada Pharmacy Alliance
Adam Porath, PharmD, Nevada Society of Health System Pharmacists
Vasudha Gupta, PharmD, Nevada Pharmacy Alliance
Michael Moeini, Americans for Prosperity
Tess Opferman, Nevada Women's Lobby
Laniqua McCloud
KayLynn Bowman
Annette Magnus
Matthew Kopko, DailyPay, Inc.
Sangeetha Raghunathan, Earnin, Inc.
Peter Aldous, Legal Aid Center of Southern Nevada
Sandy O'Laughlin, Commissioner, Division of Financial Institutions, Department of Business and Industry
Beth Slamowitz, PharmD, Senior Policy Advisor on Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services
Yenh Long, State Board of Pharmacy
Elizabeth MacMenamin, Retail Association of Nevada
Nick Vander Poel, Reno + Sparks Chamber of Commerce
Krystal Riccio
Amy Hale, Nevada Pharmacy Alliance
Paul J. Moradkhan, Vegas Chamber
JoAnn Malay, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 190.

SENATE BILL 190: Provides for the dispensing of self-administered hormonal contraceptives. (BDR 54-3)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
This bill will allow women to access birth control in Nevada without a prior prescription from a physician and with full coverage from their health insurance. Some of you may remember hearing S.B. No. 361 of the 80th Session. It was passed by the Senate, but we lost time at the end of the Session, and the bill was not heard in the Assembly. Therefore, I am back again to try to improve women's access to essential health care in Nevada.

We consider birth control to be essential health care. This bill will work to eliminate more barriers to access and level the playing field for women. Some women may have to wait months for an appointment with their obstetrician/gynecologist (OB/GYN) to get a prescription for birth control. Other women may lack access to transportation to and from appointments, limiting their ability to obtain a prescription. For many Nevada women, the barrier lies in finding the time while they juggle multiple roles, including providing care for family members, working and assisting with their children's education. This is why it is essential to open up access for women to get what we know to be safe forms of birth control. None of these things should mean that women have to forego caring for their own health and well-being due to a lack of access to contraceptives.

Studies show that 99 percent of sexually active women have used a form of birth control at some point in their lives. We do so for varying reasons, whether to finish our education, attain a career goal or wait to have a family until we are ready. Birth control empowers women to make decisions that are right for our own bodies.

Medical research also supports this. From treating acne to ovarian cysts, birth control has been prescribed to millions of women to benefit our health. Over the course of decades, research shows that access to birth control has a direct link to reduced infant and maternal mortality. This is part of the reason why the American College of Obstetricians and Gynecologists supports allowing pharmacists to dispense contraceptives to increase access. This is why I am presenting S.B. 190.

This bill is a result of hours of conversations with medical experts from across the State and the Country. One of those is Dr. Sandra Koch, an OB/GYN with more than 30 years of medical experience.

SANDRA KOCH, M.D. (Nevada State Medical Association; American College of Obstetricians and Gynecologists):
I want to speak about pharmacists dispensing hormonal birth control. First, the bill applies only to birth control methods that women take themselves, so they are self-administered, and that contain progestogen or progestogen and an estrogen component.

The effort to make access to these types of contraceptives more available to women by making them available over the counter began over a decade ago and has the support of the American College of OB/GYN, the American Medical Association and many other national medical and nursing organizations.

In its review, the Food and Drug Administration (FDA) found that hormonal contraceptives are very safe. Progesterone-only methods have extremely rare contraindications, and the major risk of methods that contain estrogen is an increase in blood clots that applies to a very small subset of women. Multiple studies have demonstrated that women who are at high risk can use a simple health screening questionnaire to identify themselves. Current U.S. law requires patients to have an appointment with a healthcare provider to start or continue contraception. Unfortunately, that is a barrier. Some women cannot obtain a prescription or a refill, and they end up with unwanted pregnancies.

The FDA has not approved any hormonal contraceptives for over-the-counter use at this time. Allowing pharmacists to dispense these contraceptives with the assistance of a self-administered screening questionnaire is a step in the right direction, making these contraceptives more available to women. Pharmacy access to hormonal contraception means women could go into a pharmacy, fill out a questionnaire, check their blood pressure and then request and receive their choice of a safe method to prevent pregnancy. Based on the answers on the questionnaire, they could choose between birth control pills, a birth control patch or a birth control ring. Clearly, this will make it easier for women to obtain them.

Some people worry that women who obtain birth control from pharmacists will not get recommended preventative care if they do not have to see a physician to get a prescription for birth control. A study was done comparing women in Texas, where a prescription is required to buy contraceptives, with women in Mexico, where contraceptives are sold over the counter without a prescription. This study showed that both populations had a good rate of receiving preventative health screens. We OB/GYNs still recommend that women see their doctors regularly. However, delaying or missing an appointment should not be a reason for women to be denied contraception.

I strongly support S.B. 190 and giving women one more tool to control their own fertility.

SENATOR CANNIZZARO:
I will walk you through the bill.

This bill requires the State's Chief Medical Officer to issue a standing order that allows pharmacists to dispense birth control to women in Nevada. Currently, 13 states and the District of Columbia have similar laws allowing pharmacists to provide birth control without a prior prescription, whether through a standing order, practice protocols or expanded scope of practice.

I will discuss each of the bill's sections slightly out of order.

Section 8 of S.B. 190 requires Nevada's Chief Medical Officer or his or her designee to issue a standing order allowing pharmacists to dispense self-administered hormonal contraceptives to any patient. The State Board of Health must work with the Chief Medical Officer to adopt regulations establishing a protocol for dispensing these contraceptives. The State Board of Pharmacy must adopt regulations prescribing a risk-assessment questionnaire to be administered upon request to patients who request self-administered hormonal contraceptives, as well as the information that must be provided in writing to these patients. Section 8 also requires the Division of Public and Behavioral Health to post on its website a link to a list of the pharmacies that dispense contraceptives as authorized by this bill.

Section 3 of the bill allows pharmacists to dispense self-administered hormonal contraceptives under the Chief Medical Officer's standing order regardless of whether the patient has obtained a prescription from a practitioner. Before pharmacists can dispense these contraceptives, they must provide the risk-assessment questionnaire to any patient who requests it. If the results of the questionnaire indicate that it is unsafe to dispense self-administered hormonal contraceptives, the pharmacist may not dispense the contraceptive to the patient and must refer that patient to a healthcare provider.

Additionally, pharmacists must create and maintain a record of each person to whom a self-administered hormonal contraceptive has been dispensed, including the name, the drug dispensed and other relevant information required by the protocol. Pharmacists must inform patients of proper administration and storage of the contraceptive, potential side effects and the need to use other methods of contraceptive if appropriate. Certain written records related to the request or dispensing of self-administered hormonal contraceptives must also be provided

to patients regardless of whether a contraceptive is dispensed. Finally, any pharmacy wishing to dispense self-administered hormonal contraceptives is required to notify the State Board of Health.

Sections 5 and 6 of the bill amend the scope of practice of a pharmacy to include dispensing self-administered hormonal contraceptives and authorize the State Board of Pharmacy to suspend or revoke a certificate to practice as a registered pharmacist if the pharmacist dispenses such contraceptives without complying with the provisions of section 3.

Sections 7 and 9 through 15 require certain health insurers, including Medicaid and State and local government employer-based plans, among others, to cover self-administered hormonal contraceptives dispensed by a pharmacist.

I would like to note that we have worked to ensure the provisions of this bill include safety protocols so that women who may need to see a physician are referred to a practitioner. Another key part of the bill is ensuring that insurance, regardless of whether the woman receives the contraceptive from a practitioner or a pharmacist, will cover that contraceptive the same.

Senate Bill 190 is essential in allowing Nevada women to have easier access to birth control. I urge your support of this bill.

Dr. Koch has provided documents to the Committee that deal with a number of studies with recommendations from different healthcare providers and boards that talk about what we are dealing with, in terms of allowing pharmacists to dispense contraceptives.

CHAIR SPEARMAN:
I would imagine this would be a help to women who live in rural and frontier communities in terms of access. Can you speak to that?

SENATOR CANNIZZARO:
I appreciate the question, since that is a critical piece of S.B. 190. The bill is seeking to remove barriers to access to hormonal contraceptives that are known to be safe. It is a barrier for women in rural communities to have to go a long distance to see a practitioner to get a prescription for a medication we know to be safe and that they can administer themselves. We are removing that barrier and allowing them to have easy access to hormonal contraceptives. That would

also apply to women who are in areas where transportation is hard to come by. Some lower income areas would definitely fall into that category. By removing this barrier, we are opening up that access.

This bill also plays into the overall conversation about women's health. As I said, hormonal contraception can help to reduce fetal and maternal mortality. The bill also allows women to have better control over their own healthcare decisions. It should also be noted that nothing in S.B. 190 stops women from going to an OB/GYN. It does not mean we are going to stop taking care of ourselves. There are a number of other services we receive from OB/GYNs. This bill is strictly related to hormonal birth control. If there is something in the woman's history or healthcare background that would require them to see a practitioner before it would be safe to administer that hormonal contraceptive, it will be flagged by the questionnaire.

VICE CHAIR NEAL:
What would be in the questionnaire? The self-assessment could potentially not address all of the possible risk factors.

SENATOR CANNIZZARO:
The bill does not prescribe the exact questions to be included in the questionnaire. Rather, section 8 directs the State Board of Health to work with the Chief Medical Officer and the State Board of Pharmacy to adopt regulations, including what would be contained in that questionnaire and what information must be provided to the patient. We are leaving the exact questions to be asked up to the best medical expertise to decide.

VICE CHAIR NEAL:
Section 3, subsection 3, paragraph (a) of the bill says, "The pharmacist or his or her employer shall maintain the record … " The employer could be Walgreens or CVS. Is there a confidentiality issue with employers storing this information? Should there be some other mechanism in place?

SENATOR CANNIZZARO:
We added this language because it is consistent with current practice. If you go to Walgreens with strep throat and are given a prescription for amoxicillin by the pharmacy, it will be on record the next time you go there. The pharmacist and the pharmacy both need to have that record. Again, that is consistent with current practice.

SENATOR HARDY:
I may have misheard, but I think you said if there is a risk, the pharmacist "may not" dispense. The language in the bill is clear that if there is a risk, the pharmacist "must not" dispense. This keeps the pharmacist from getting trapped in a "Please, please, please," scenario. The pharmacist must not dispense if there is a risk factor.

Speaking of risk factors, it should be noted that risk factors change. How long is the prescription for, and how often is the questionnaire renewed?

SENATOR CANNIZZARO:
You are correct that the language in the bill is "must not," not "may not." When I said "may not," that was my mistake. Our intent was that if there is something in the questionnaire that indicates it would not be safe for the person to receive self-administered hormonal contraceptives, there is no mechanism by which the pharmacist can override that and dispense the contraceptives. Rather, the mechanism is to refer the person to a practitioner who can do a more thorough evaluation to find a contraceptive the person can have safely. Most women will not fall within that category, but some will need to see a physician.

With respect to the risk factors, I believe it was in 2017 that we passed legislation allowing 12 months of birth control to be dispensed at once. Previously, it had been three months, so it had to be renewed once a quarter. This bill does not change that, so patients could receive 12 months at a time. The intent is for the risk assessment to be done every time patients come in to fill the prescription. Again, though, that is left up to the regulations to establish.

SENATOR HARDY:
Is it your intent to have the questionnaire filled out at least every 12 months?

SENATOR CANNIZZARO:
Yes, at least every 12 months. That way we can ensure the patient is properly protected if the risk factors have changed or some other health issue has come up.

SENATOR HARDY:
I appreciate your bringing this bill up. It has been a long time coming.

SENATOR SCHEIBLE:
I love this bill. It is incredibly important and is great public policy. To me, requiring a prescription for birth control makes as much sense as requiring a prescription for condoms.

I want to check my understanding on what I see as one of the advantages of this bill. Let us say the birth control I am currently using is not working for me. I have to take it every night, and I do not always remember. I need something more flexible, but I am not sure if I want the ring or the patch. If I go to my doctor with that problem, he or she would then prescribe a different contraceptive, and I would go to the pharmacy, get that prescription filled and try the new contraceptive. I might then come back to the doctor again and say, "The patch was itchy; let me try the contraceptive ring." I would then have to get a new prescription, go back to the pharmacy to fill it and repeat the process until I find something I like. This bill would allow me to go to the pharmacy, get the patch, use it for a month, then go back to the pharmacy and get the ring without another trip back to the doctor.

SENATOR CANNIZZARO:
This is one of the things women go through when trying to manage their own health care. When a woman has an issue with one form of birth control, we want her to see her OB/GYN to have an in-depth conversation to find out what is going on. It might be a lifestyle issue rather than a medical issue. In the case of the itchy patch, that might be evidence of an allergic reaction, and that is the kind of event that would be caught by the questionnaire that would send the woman to her practitioner for additional follow-up.

In essence, if a woman wants to receive birth control without visiting a physician, under S.B. 190, a pharmacist can certainly do that. She will still need to go to an OB/GYN to get pap smears and other tests. If she decides she wants to use hormonal birth control, she can walk into a pharmacy without a prescription, fill out the questionnaire, and absent any red flags that show up on the questionnaire, that contraceptive would be dispensed.

SENATOR SCHEIBLE:
The bill would also mean if I go back to Las Vegas during Session and forget my birth control here in Carson City, I can go to a pharmacy in Las Vegas and pick up a new one without missing three or four days of treatment and risking an unwanted pregnancy.

SENATOR CANNIZZARO:
Yes. There is nothing in the bill that would prevent a woman from seeking birth control from another pharmacy.

SENATOR SCHEIBLE:
I am interested in the future of the standing order from the Chief Medical Officer. What happens in future years, when there is someone else in that position? Is this order subject to change?

SENATOR CANNIZZARO:
That came up in the conversations about S.B. 190. The bill requires the Chief Medical Officer to have the standing order. Even if there is a change in administration, that standing order would still be required.

ANN SILVER (CEO, Reno + Sparks Chamber of Commerce):
Our organization fully supports S.B. 190 as part of its longstanding commitment to the rights of women and their ability to secure contraceptives without a lengthy and often intimidating process. Making access to contraceptives easier and more efficient means women will be better able to continue multitasking as parents by choice, professionals and effective community participants. We urge swift passage of S.B. 190 as evidence of your support for women in Nevada.

CHRISTINE SAUNDERS (Progressive Leadership Alliance of Nevada):
We are in support of S.B. 190. Access to contraception is a much broader issue than just pregnancy prevention. When we extend access to birth control, we extend women's economic opportunities. This bill will help ensure all women, particularly those in marginalized communities who lack access to stable and affordable health care, have control over their health and future. We urge your support of this bill.

ELIZABETH DAVENPORT (American Civil Liberties Union Nevada):
We are in support of S.B. 190. Removing barriers to access to birth control has broad positive impacts in economics, educational opportunities, racial justice and other areas. Difficulty accessing birth control disproportionately affects Black women and other people of color. Black women are more than three times as likely to have physical conditions that are treated with hormonal birth control. Removing a barrier to accessing birth control can only benefit all communities.

Further, multiple studies have shown access to birth control is one of the most influential factors in enabling women to stay in college. It has been linked to a 20 percent increase in enrollment and a 35 percent decrease in drop-out rates. Additionally, *Bloomberg Businessweek* has listed contraceptives as one of the most transformational developments in the business sector in the last 85 years. It has helped narrow the wage gap between men and women.

Removing barriers to access birth control removes barriers to education, jobs and health care.

VICTORIA RUIZ-MARIN (Planned Parenthood Votes Nevada):
We are in favor of S.B. 190. Allowing pharmacists to dispense birth control is crucial to increasing access to a foundational component of sexual and reproductive health care. Birth control has been key to improving women's health, social and economic condition, as well as preventing pregnancy, since its inception. The ability to plan your parenthood can profoundly affect your ability to pursue a career and other opportunities.

Additionally, birth control is essential to treat certain health conditions. Access to birth control helps mitigate the barriers for communities of color and low income who already experience disproportionate maternal mortality rates and health disparities that the Covid-19 pandemic has exacerbated. Allowing pharmacists to dispense birth control will help give Nevadans autonomy over their health. I urge you to support this bill.

SERENA EVANS (Nevada Coalition to End Domestic and Sexual Violence):
We are here today in support of S.B. 190. Having easy and affordable access to birth control is important for everyone, especially victims.

Accessing health care is a challenge for many Nevadans, and for victim survivors who are constantly watched by their perpetrators, accessing a healthcare professional to get access to a birth control prescription is not always feasible or safe. In some instances, perpetrators will accompany the victim survivors to every doctor appointment to assert power and control and to sabotage their use of birth control. Being able to access birth control over the counter at a pharmacy may allow a victim survivor the ability to access birth control and prevent unwanted pregnancies with the perpetrator.

Allowing people to access birth control from pharmacists directly will greatly decrease barriers for many Nevadans and can have positive, important impacts for victim survivors.

CAROLINE MELLO ROBERSON (NARAL Pro-Choice Nevada):
We are proud to be in support of S.B. 190. I have submitted a letter (Exhibit B) describing the importance of this bill.

MARCOS LOPEZ (Americans for Prosperity Nevada):
We are in support of S.B. 190. I have written testimony (Exhibit C) voicing our support.

KEN KUNKE, PHARMD (Nevada Pharmacy Alliance):
We are in support of this bill. I have submitted a flier titled "Pharmacists Expanding Nevadans' Access to Care" (Exhibit D) on this topic.

We are excited to expand our ability to take care of patients. Nationally, 68 percent of women report barriers to acquiring contraceptives in the United States. While this number is concerning, there are steps we can take to improve the situation. Currently, 12 states have laws in place that allow pharmacists to dispense hormonal contraceptives, and they are proving that this process works. A study from California and Oregon shows a reduction in unintended pregnancies since the passage of a law of this type. In addition, 74 percent of women who received hormonal contraceptives from a pharmacist report that they had no use of birth control in the previous six months. This does not surprise me. Pharmacists are the most accessible healthcare professionals, and they are able to provide services like this to patients throughout Nevada. In fact, 90 percent of Nevadans live within five miles of a pharmacy, and patient consultations are a normal part of a pharmacist's day.

I ask you to support S.B. 190 so pharmacy teams can start providing access to hormonal contraceptives in Nevada.

ADAM PORATH, PHARMD (Nevada Society of Health System Pharmacists):
We support S.B. 190. Pharmacists are ready and willing to help in this regard. In a national survey, over 85 percent of pharmacists are interested in providing this sort of service for our patients.

VASUDHA GUPTA, PHARMD (Nevada Pharmacy Alliance):
I am an associate professor at Roseman University of Health Sciences, College of Pharmacy, and a board-certified clinical pharmacist at a federally-qualified health center in Henderson. The Nevada Pharmacy Alliance fully supports S.B. 190.

Pharmacists have a doctoral degree with a focus on medication management. They are highly trained professionals but unfortunately are underutilized. Allowing pharmacists to dispense safe and effective hormonal contraceptive medications will significantly improve access to care to women who want to prevent pregnancy, as well as allowing pharmacists to have discussions with patients about safe sex practices. This bill will help to reduce unintended pregnancies and decrease the burden on our healthcare system.

One important topic that has not been touched on so far is insurance coverage. I cannot tell you how many times I have dealt with this personally as a patient and as a healthcare provider. With our healthcare system, insurance provider coverage changes constantly, and medications are often not covered. What typically happens is one prescription is sent to the pharmacy. If it is not covered, the patient has to call the provider and then check back with the pharmacy to see if the new medication is covered. This may occur several times before it is finally determined which medication is actually covered by the insurance provider. This can delay access by weeks and cause an unnecessary burden to both patients and physicians. If the entire process is done at the pharmacy, it is easy for the pharmacist to determine which prescription will be covered, and it can be dispensed then and there. This will make the process a whole heck of a lot easier.

MICHAEL MOEINI (Americans for Prosperity):
The driving ideology behind Americans for Prosperity lies in removing barriers and empowering citizens, and we believe S.B. 190 accomplishes both of these. Women have a right to purchase contraceptives without government either forcing them to obtain a doctor's permission or increasing the price of birth control. There are a myriad of reasons why someone may not have access to an OB/GYN but do have access to a pharmacy. As a father of three young girls, I believe my daughters have the same right to easy access to birth control and being in charge of their reproductive futures as someone else's sons.

TESS OPFERMAN (Nevada Women's Lobby):
We support S.B. 190. I echo what those who spoke before me have said this morning. This bill is critical to creating easy access to birth control and ensuring women are able to make decisions about their bodies and their futures. Allowing pharmacists to distribute birth control means women can easily access necessary preventative birth methods without doctor's appointments and without insurance. This is a huge step for women's health.

LANIQUA MCCLOUD:
I am in support of S.B. 190 as it applies to women having more options and availability with getting contraceptives over the counter. It is in our best interest for women to have that personal choice, and that power is given back to us as women.

KAYLYNN BOWMAN:
I am a licensed pharmacist who has been practicing in Nevada for 14 years. The legislation proposed in this bill will improve timely and equitable access to hormonal contraceptives to women in Nevada. Pharmacists are trusted members of the healthcare system in Nevada, and we are accessible and readily available to meet patient needs for not just medications but for other healthcare needs.

How will this bill work for me as a pharmacist? While ringing up Plan B emergency contraceptives, we could have a conversation about getting on more consistent birth control and lowering the risk for unwanted pregnancies. When a young college student does not have a provider or health insurance and is seeking information on how to get care, I could get her started on hormonal contraceptives and give her a provider referral. When a woman is out of refills and it is the weekend, I could provide her with additional medication, thereby reducing the chance of missed doses.

Overall, pharmacists are practicing in a dynamically changing healthcare environment. To progress, we have to work collaboratively and effectively to improve patient care. That is why I am asking for your support for S.B. 190.

ANNETTE MAGNUS:
I am the executive director of Battle Born Progress, but today I am speaking in my personal capacity in support of S.B. 190.

Just last weekend, I had an experience with my own birth control where I was not able to renew my prescription. I have horrific periods that cause horrific migraines. I have been taking birth control for years to control my migraines, my periods and my cramps. Last weekend, my birth control ran out. I called the pharmacy to renew my prescription, and because of the way my doctor has directed me to take these pills, I always run out of my prescription early, and my insurance will not cover more. I have to call my doctor to get the prescription reauthorized by my insurance. I have to go through a hundred different steps every month.

I am lucky; I worked for a healthcare provider, so I understand the process. But another woman might not have the knowledge or privilege that I had to navigate that system. Because I had to navigate that system, I missed almost five days of pills, and then I started my period and had a horrific migraine. There is no medical reason for this delay. I have been doing this with my pills for years. I should have been able to walk into the pharmacy, have the pharmacist renew the prescription and had that conversation directly with the pharmacist so I did not have to go through the migraine.

There are thousands of women who take birth control in Nevada who are counting on you to make to it easier and more accessible. Many of them do not know how to navigate the system when it is medically necessary. They need this medication to be able to control their fertility and meet their medical needs. I am asking you to pass this bill today for the thousands of Nevadans who are counting on you. This is medicine, and they need access to it.

VICE CHAIR NEAL:
Pharmacists have a National Provider Identifier that lists them as providers. Will this bill allow pharmacists who are now engaged in extra activities to make a profit when they dispense these medications, or will it go into their employers' fee structure?

SENATOR CANNIZZARO:
I do not have an answer on that. The bill allows pharmacists to have that extended scope of practice to provide birth control. I will get an answer for you.

We were careful in crafting this bill to make sure the pharmacist would not charge an additional fee for providing birth control. We wanted the costs to be

covered by the patient's health insurance, with no additional charges to make it cost prohibitive for women to use this as a form of access.

SENATOR HARDY:
We should recognize that this bill will probably prevent unwanted pregnancies and thus reduce abortions. It is optimistic to assume patients will continue to have pap smears and other screenings done as often as they do now. On balance, I think the bill is a good thing, but there are downsides that all of us need to be aware of.

SENATOR CANNIZZARO:
Women go to the OB/GYN for a variety of reasons, not the least of which is to obtain birth control. Certainly, some forms of birth control, even under this bill, have to be administered by an OB/GYN, such as an intrauterine device (IUD). Pharmacists would not be able to dispense IUDs.

This bill is not meant to say, "We don't want people to continue to see their OB/GYNs for regular checkups." We need to do a better job of trusting women with their own health care, not only as a Legislature but as a society and in our communities. We trust patients all the time. If you buy Theraflu from the local Walgreens, we trust you to go to a doctor if your illness does not respond or gets worse. We should be trusting women with their own health care. If anything, we need to do a better job of ensuring women know they have to get regular pap smears and breast exams to catch different types of issues that may arise.

I do not think this bill diminishes that, and we should not be putting up barriers for women to attain contraceptives on the premise that the only thing driving them to get pap smears is the need to get a prescription for birth control. Barriers to birth control do not mean women will go see their OB/GYNs; it just means they will go without either health care or birth control. If we can remove one of those barriers, that is the important crux.

I passionately believe this is something we must do to help expand women's access to health care, to allow women to make those choices for themselves. This is something we know to be safe; this is something we know can be administered properly by a pharmacist. This is going to reduce those barriers and help with fetal and maternal mortality. It is going to help address some of the issues we have with unintended pregnancies.

These are the kinds of questions at the forefront of this bill and what it is intended to get at.

VICE CHAIR NEAL:
I will close the hearing on S.B. 190 and open the hearing on S.B. 198.

SENATE BILL 198: Provides for the regulation of on-demand pay providers. (BDR 52-847)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
This bill seeks to regulate earned wage access providers, limiting their ability to sell personal information and ensuring there are sufficient consumer protections for consumers who may wish to utilize these types of applications. I have a presentation (Exhibit E) that gives background information on the industry.

One of the reasons this is a pertinent conversation relates directly to what we are seeing in many of our communities. Many people are still struggling financially as a result of the Covid-19 pandemic; even without that, however, many Nevadans live paycheck to paycheck. For these workers, the slightest unplanned event, often common life occurrences, could upend their financial stability. A child gets sick and needs to go to the hospital—a prescription needs refilling—a car breaks down or gets a flat tire. For Nevadans living on a tight budget, everyday events like these are difficult to navigate, particularly if they occur in the middle of a pay period.

I grew up in a family where we definitely lived paycheck to paycheck, and I have lived like that myself prior to my current career. In that situation, even the smallest life event can be devastating. Sometimes, it is a matter of asking your folks for a little bit of money so you do not bounce checks. Sometimes, it is a matter of digging through the sofa for spare change. These are the kinds of things everyday Nevadans face. Research shows that more than 75 percent of all full-time workers in the United States live paycheck to paycheck.

One of the ways we are seeking to relieve this situation is with earned income applications. These applications allow workers to request and receive wages as they earn them. As life's unexpected events arise, earned wage access applications enable employees to receive their wages before their next normally scheduled payday. Instead of struggling to get by, overdrawing their accounts and paying large compounded overdraft fees, or turning to high-interest payday

loans just to make it through, they can have access to wages they have already earned.

Earned wage access began with the development of the gig economy and spread from there to traditional businesses. In 2018, for example, Walmart rolled out an earned wage access service, and more than 250,000 of its employees used the service in just the first year. According to Walmart's senior benefits manager, the company added that benefit to help workers avoid expensive payday loans and late fees.

There are different types of earned wage access programs. In-house programs are those where employers offer the earned wage access through existing payroll services and partnerships. Under these programs, the employer funds the earned wage access service and has complete discretion over the amounts and frequency of employee paychecks. Third-party vendor programs are those where employers or employees select a separate company to provide earned wage access. The vendor pays the employee the amount and takes it from the employee's net pay on the employer's scheduled payday. However, some third party vendors have very little involvement with the employer, providing the service directly to employees and requiring the employee to repay the amount to the vendor on payday.

While earned wage access pay may offer benefits to both employers and employees, there are consumer protections we must consider. In Nevada, we lead on consumer protection. One of our most sacred jobs as legislators is to protect Nevada consumers from unscrupulous and dangerous products and services. We have a long history of thoughtful, balanced financial regulation in this State. That should continue with these applications as well. That is why I introduced S.B. 198.

This legislation leads the Nation in regulating a new promising market alternative that has the power to bring much-needed relief to hardworking Nevadans. Particularly in these difficult times, as families are struggling, we need to find safe, secure means for Nevada families to avoid predatory credit finance.

Earned wage access is a new technology that enables employers to pay their employees as frequently as they need without disrupting current payroll processes. However, as with any industry, there are of course good actors and bad actors. This legislation is intended to establish a full regulatory regime of

customer protections and requirements. Earned wage access can only be done if the employer is closely involved. That is the best way to ensure consumers are not being taken advantage of. With the employer involved, it becomes a nondiscriminatory benefit, just like any other employee benefit, and there is no individual underwriting. This service should not be based on income level, skin color, gender or any other demographic.

Employer involvement is critical to verify and seamlessly provide earned wages. Without the employer, you cannot verify what wages have been earned and what payments are a loan against future wages. Critically, without the employer, you may be forced to debit consumer bank accounts, which often results in overdrafts, when we are supposed to be preventing them. Without the employer involved, there is a strong possibility that this becomes nothing more than internet payday lending by another name.

Nevada must act now. Failure to pass S.B. 198 may expose hardworking Nevadans to potential bad actors in this industry. Some companies that are not integrated with employers put themselves forth as being employer-integrated systems and can take advantage of unsuspecting customers who may rack up incidental overdraft fees or be tricked with deceptive business practices like calling loans gifts or by asking them to pay additional interest in the form of tips.

This legislation is intended to ensure there are sufficient protections to guard against some of these predatory practices. This legislation requires licensure, consumer protection, transparency, employer verification and more. It prevents general solicitation of the public, but the service can be offered in a way that is secure and trusted by the employer and employee alike.

We provided a conceptual amendment (Exhibit F) that is very much a work in progress with some of the other stakeholders involved, including Legal Aid of Southern Nevada and the Division of Financial Institutions (FID), Department of Business and Industry, to ensure that we can get the policy on this right. I will go through the bill and then discuss briefly some of the points in the conceptual amendment so the Committee is aware not only of what the bill is seeking to do but also where we are in terms of negotiations.

Section 12 of S.B. 198 requires a person who wishes to provide earned wage access services as an employer-integrated earned wage access provider to

obtain a license from the Commissioner of the FID. That license will expire annually. The Commissioner is required to adopt regulations establishing fees for issuing and renewing that license.

Sections 12 and 13 also require the Commissioner to develop an application for licensing as an employer-integrated earned wage access provider containing certain information, including but not limited to the applicant's financial statements for the immediately preceding year, which must have been audited by an independent certified public accountant (CPA); a copy of the proposed terms and conditions of use, which will govern the provisions of the earned wage access services; a copy of the policy concerning the privacy of the user's information; the schedule of fees proposed to be charged to user or employer; a statement from the applicant relating to possible child support court orders; and any information required by regulation that may be adopted by the Commissioner pursuant to section 19 of the bill.

Section 15 of the bill requires an employer-integrated earned wage access provider to submit a report to the Commissioner on or before June 30 of each year. The report must contain financial statements of the immediate preceding year that have been audited by an independent CPA; a copy of each complaint filed against the provider with the Better Business Bureau or the Consumer Financial Protection Bureau (CFPB); and a description of the resolution, if any, for each complaint.

Section 16 requires an employer-integrated earned wage access provider to develop and implement policies and procedures to respond to questions and complaints from users; before entering into an agreement with the user, inform the user of his or her rights under the agreement; fully and clearly disclose all fees associated with the earned wage access services; allow the user to cancel at any time without incurring a fee; comply with all local, State and federal privacy and information security laws.

Section 17 of the bill provides that if an employer-integrated earned wage access provider is unable to be repaid the amount of money delivered to a user, absent fraud by the user, the provider is prohibited from collecting or attempting to collect that money from the user or reporting any information regarding the inability of the provider to be repaid to a consumer reporting agency.

Section 18 also prohibits an employer-integrated earned wage access provider from sharing with an employer any fees that were received from or charged to a user, or paying any other compensation to an employer that is directly related to any fees received from or charged to a user.

Sections 20 through 22 set forth that providing earned wage access services by an employer-integrated earned wage access provider shall not be deemed loans, and laws governing a person engaged in the business of transmitting money do not apply to employer-integrated earned wage access providers. However, earned wage access services provided by third-party earned wage access providers are deemed loans and are subject to the laws governing high-interest loans.

With respect to Exhibit E, the bill as amended will include some of the following consumer protections. We are looking for limitations on what providers can call fraud, raising it to intentional and willful fraud; limitations on debiting authority; requirements for a new mechanism for FID to provide input regarding additional future rules and regulations, should they be warranted; strengthening FID's examination, supervision and licensure authorities; a surety bond requirement; a requirement for retention of books and records; a requirement to notify FID in a timely manner of any changes to corporate address, name or trade name, commonly known as its "doing business as" (DBA) name; a provision that the license is nontransferable; changes to conform with FID's licensing schedules; access to books and records in-State; reimbursement for the costs of any supervision, audit, examination, investigation or hearing conducted out of State; all fees and assessments, including application, initial licensure, renewal license, examination, CPA and Attorney General fees; and disciplinary action, including license suspension.

As I mentioned, we are still in the process of working with the FID and Legal Aid to work on these amendments and some additional changes. We look forward to coming to a resolution that will provide the highest protections for consumers while ensuring they have access to this new important format.

I urge your support of S.B. 198.

SENATOR PICKARD:
I was unaware of this industry until I read the bill and your lobbying team called and we talked about it. That was helpful; I appreciate your doing that in advance.

This bill creates a new license requirement. What happens if employers are already doing this on their own? I am unclear if they are required to be licensed to do this if they are going to offer this as an in-house operation.

SENATOR CANNIZZARO:
We want to ensure that any entity that supplies this service is licensed so they adhere to FID regulations. One of the safest ways is having that employer integration with the companies, which is why we focused on that in the bill. With employer integration, the service can verify that the person actually works there and that there are wages to be paid. The service is not providing some sort of advance on the person's wages; rather, it is integrating with an employer. If this is done in-house by the employer, it may still fall within the bounds of the bill. The most common way to provide this service, even with an in-house agreement, is through a vendor who integrates with the employer. That vendor would need to be licensed.

SENATOR PICKARD:
That makes all the sense in the world. I would expect that if an earned wage access provider links up with an employer's payroll system and then offers that through the provider's system, that provider would have to have a license.

My understanding was that Walmart and Target offered this service through their own payroll systems, so they are offering payment on the go as opposed to accruing wages that are paid at the end of the period. National chains like Walmart and Target are probably going to have the wherewithal to do this completely in-house. For smaller outfits, though, this would not work.

Take my law firm, for example, with 11 people working for us. We do not have internal payroll operations; we contract with a provider to issue paychecks. If I were to say, "Okay, I'm going to do this on-demand earned wage thing on an internal basis," am I going to be required to be licensed, or would it be the paycheck company that would do it? What happens if they are already licensed through FID? If my bank offers this service, does it have to get a second license? I am just trying to figure out who the licensees are.

SENATOR CANNIZZARO:
There is a bit of confusion around this. Most employers have a two-week pay period. If you were an employer who wanted to change to a weekly pay period, that would fall within the agreement you have with your payroll company more than with this type of service. We would not consider that to be in-house, since it would be handled by your payroll service.

When corporations that do all their own payroll services in-house choose to contract with an outside company to provide pay on demand, the outside company needs to integrate with the corporation's systems to provide the service. That is the company we are seeking to license: the employer-integrated on-demand pay provider that is not part of the larger corporation. That is what this bill is seeking to do. It is employer integration when the employer is working directly with the vendor. It is not employee to vendor; it is employer to vendor.

If you were going to set this up as an employer, you are either talking about changing the way you do payroll or you are talking about using one of these employer-integrated systems. That is what we are seeking to license. Most employers are not going to set up their own payroll system just so they can pay their employees early. It can be very costly.

MATTHEW KOPKO (DailyPay, Inc.):
Senator Cannizzaro is correct. Most leading employer-based vendors work not just with employers, large and small, but also with professional employer organizations (PEOs), payroll firms and other financial infrastructure firms regarding payroll.

I believe your question relates to employers who build their own on-demand pay system from scratch fully in-house, i.e., without the use of a third-party vendor. Most employers do this through a vendor. If you were to do this entirely in-house, the regime under the bill would not apply to you, from my reading of it. This bill is specific to employer-integrated on-demand pay providers. An employer providing a similar service or running payroll more frequently in-house would have to follow their own existing compliance procedures, just as if they wanted to run payroll daily. The overhead would be significant, which is part of why they do not do that and part of why the market is moving toward these vendor-based relationships.

SENATOR PICKARD:
I would like to understand where this bill would apply, and where it would not apply. Maybe using my own firm was a bad example, because with 11 people it is too expensive to try to do a payroll run every day. Let us talk about companies with 100 to 500 employees. We are talking about a significant operation where your economies of scale may come into play. At what point is a license required? The employer may still be working with a payroll provider, and maybe that provider will set up a pay structure, a cost structure so that it makes it so that the employer can actually offer the on-demand or frequent payment.

I am trying to tease out the line where the bill no longer applies. Does that make sense?

MR. KOPKO:
Yes, your question makes sense. The bill requires the licensure of the service provider that would be facilitating the on-demand pay service. Employers would not have to register under this bill. Firms like ours tend to work not only with employers but also with payroll providers, PEOs and other companies like that. There is no case in which the employer would be required to be licensed. It is just an employer, which is also defined in the bill. Licensure would be limited to the actual provider of on-demand pay services.

SENATOR PICKARD:
Section 17, subsection 1 of the bill refers to a situation in which a provider "is unable to be repaid." That tripped me up. The bill is talking about a more frequent payroll processing as opposed to a loan. I am trying to figure out how repayment would be required when we are talking about payroll.

SENATOR CANNIZZARO:
That is an important point of distinction. It has to do with instances where there may have been a discrepancy. The intent here is to ensure that the employee will not be charged if there was some sort of discrepancy along the way because there is nothing for them to pay back. There are actors in the industry who may be giving what amounts to a loan or a paycheck advance that would have to be repaid. We are trying to ensure that does not happen here. If there were a discrepancy, the employee would not have to pay that back.

MR. KOPKO:
Section 17 is intended to be one of the key consumer protections in S.B. 198. It points out that to the extent an employer is either delinquent or unable to make payroll, the provider cannot look to the employee for recourse. It is considered a non-recourse section to protect consumers. As you can imagine, from time to time, employers in bad economic circumstances do not make payroll. This guarantees that the provider cannot look to the employee for repayment. Its arrangement is with the employer as the facilitator of the on-demand pay services, and any discrepancies in the payroll should be resolved with the employer.

SENATOR PICKARD:
This, then, is not talking about repayment of a loan but repayment if there is a discrepancy in the payroll processing. If the employee is inadvertently overpaid, it is not the fault of the employee; it will have to be resolved between the provider and the employer. I am assuming if the employee was paid more than was earned, that would be offset against future income so that we are not paying an employee who did not earn the wage. That would come out of future earnings. Is that a fair statement?

MR. KOPKO:
That is correct. In the normal course of business, from time to time, employers have discrepancies or errors in the payment of payroll. That is one example. More commonly, the employer misses payroll, or the money for payroll arrives late. This provision in the bill is intended to enshrine the concept that providers should not be looking to the employees for repayment. Most employers have mechanisms for resolution of errors in the processing of payroll. The on-demand pay provider serves as another consumer protection in this regard. Now you have a third party who is working to resolve any discrepancy, as opposed to employees not receiving their pay or having to petition the employer to resolve the payroll issue.

SENATOR SETTELMEYER:
Where in the bill does it limit this to only nonpayback models? In doing some research on this, I am concerned if we are going to allow payback models to access this potential licensure. Are we specifically limiting it within the bill? If so, what section?

MR. KOPKO:
In section 7, "employer-integrated on-demand pay provider" is defined as a provider who uses employer integration to verify earned income. The bill is framed such that only employer-integrated on-demand pay providers, i.e., those who do not engage in debiting activity or third-party repayment, would be licensed under this bill. The requirement is in the definition: integration with the employer, not just contractually but through payroll and data.

SENATOR SETTELMEYER:
We might want to make that a little more clear to confirm that this follows the CFPB's concepts and only applies to nonpayback models. Otherwise, as I am seeing online, this could get us into all types of problems, and we will get into discussions of credit and payback.

VICE CHAIR NEAL:
We have not talked about interest. Is any interest accrued in this transaction?

MR. KOPKO:
The bill requires full fee transparency. Because the service is not credit and the money is not a loan, just the facilitation of real-time payment, there are no interest charges. There is no loan. There are no rollover fees. There are no other hallmarks of credit involved. There is a fee for the service, but it is not interest.

SENATOR LANGE:
As the operations manager for a small business, I can see the benefits of this service. I did payroll for two businesses, and I always had employees coming to me asking for advances on their paychecks because maybe that month their rent was due before their paychecks arrived. Having another person who could do this instead of having to cut the checks would be really helpful.

How much is the fee you charge?

MR. KOPKO:
Our typical pricing structure is $1.99 for the legacy transmission, which is an automated clearing house transfer that typically takes 8 to 24 hours for the funds to arrive in the employee's bank account. There is also a $2.99 option for instant delivery, typically within about 20 minutes. Other providers have different models. There are some versions where if you use a certain type of pay card, the fees can be less, including free in some circumstances. In all

cases, the employee receives the full remainder of his or her payroll on payday, without any charges associated.

SENATOR LANGE:
So you could use like a Netspend card, a prepaid debit card, and have the money put on there?

MR. KOPKO:
Yes. Employees can direct funds to any destination account of their choosing. It is an entirely voluntary, nondiscriminatory benefit, in that if it is not used in a given pay period, there is no charge to the employee.

SENATOR LANGE:
And there is no charge to the employer, right?

MR. KOPKO:
We offer employers the ability to subsidize their employees to use this service. For those that do, it typically takes the form of, for example, one free additional transaction per pay period. We continue to see shifts in the market where that is becoming more and more common, but it is part of structuring the system. We offer a subsidization option.

SENATOR SETTELMEYER:
What size company does this work best for? Do you have a cutoff point that if you do not do this much in payroll each month, we do not deal with it? If I have only three employees, would you tell me, "You guys don't do enough quarterly to qualify"?

MR. KOPKO:
We work with employers large and small. I would say our standard employer has 1,000 or more employees, but we do have a small and medium-sized business sales division.

The exciting thing about this industry is that as it matures, we are able to build all types of application programming interfaces (APIs) to work with all the payroll providers in the industry, all the PEOs in the industry. We are often in the circumstances where this is a kind of checkbox add-on service for a small or medium-sized employer who is working with a PEO. So long as we are able to write an app and technology that works with a PEO, they can distribute that as

a voluntary offering to any of their clients. It is becoming increasingly available to smaller and smaller businesses as the industry matures and grows.

SENATOR SETTELMEYER:
You did not necessarily answer my question about your company's cutoff point. If an employer does less than $10,000 a month in payroll, does that create the limitation? Do you have a cutoff point? Do you work with guys as small as $5,000? In your specific business, is there a point where it is not economical to enter into agreements with them?

MR. KOPKO:
Typically, the enterprise sales force is focused on medium and large businesses, typically 1,000 or more employees. Again, the exciting opportunity for the small side of the business is that once you create an integration with a specific PEO, all of that PEO's clients can use the service. We used to have to build custom technology for every new client for our first few dozen clients, but now we can say, "Oh, you use ADP for payroll and you use XYZ Time Management System, we have an off-the-rack integration already built for that." It is becoming increasingly available for smaller and smaller employers.

SENATOR SETTELMEYER:
I guess I am being dense because I do not necessarily hear an answer there. I will talk to you about this offline.

I have one last question about consumer transaction fees, which are basically mandatory if you want to participate. Does that not get into the concept of credit, under regulation Z of the Truth in Lending Act? I am trying to learn all this as I go along.

MR. KOPKO:
I believe you previously referenced the CFPB guidance on this matter.

Fundamentally, the analysis of whether this is credit hinges on the payback versus nonpayback model, as you mentioned. Typically, when a transaction is credit, the fees paid are actually interest. When it is not credit, the fees paid are not interest, they are just fees—service fees, transaction fees, technology fees or something else. The reasoning and analysis in the CFPB advisory opinion points out why most employer-based services are involved in a construct that is not credit in nature.

Section 17 of S.B. 198 prohibits looking to the employee for repayment. It is more like the facilitation of realtime payroll.

SENATOR PICKARD:
I want to follow up on a statement Mr. Kopko made, and I may have misunderstood it. It sounded like there were fees of $4 to $5 on every transaction you do, with $1.99 here and $2.99 there. If we have 1,000 employees and you are doing a daily pay program, that is $5,000 a day you are making on this that you are taking from payroll. Did I understand that correctly?

MR. KOPKO:
I apologize if I was unclear. The charge is either $1.99 for the next-day service or $2.99 for the instant service, not both. Typical use patterns show employees use the service about once a week. Our vision is the idea that employees can get paid as frequently as they want, so our name, DailyPay, may be a misnomer. The standard operation of the service is not a reliance on this daily. The typical interaction is about once a week.

SENATOR PICKARD:
Are those paid out of the paycheck?

MR. KOPKO:
The fees are assessed to the employee, unless the employer subsidizes the service. There is no charge for employees who do not use the service.

SENATOR LANGE:
Let us say I run a small business and use a payroll company, say Paychex. We are working with your company, and one of my employees wants to access his or her earnings. To get that money, the employee must go through Paychex, if I understand this. You are not charging me a fee, but Paychex may charge us a fee to put this data in their system. Is that how this would work? If you have a contract with Paychex, would there be any more fees?

MR. KOPKO:
There are many integrations at play here. We integrate with a variety of leading payroll providers, including ones like Paychex and other large payroll providers. The other critical part of the system is not just payroll but integration with the employer's time management and accounting systems, so that net take-home

pay can be accurately determined and calculated. That is another benefit of the employer-based system, that you have the ability to limit this to net take-home pay.

The easiest way to think about what we do is as the technology layer on top of all the existing processes. Adding an on-demand pay provider, at least under our construct, does not require you to change your arrangement with Paychex or get a new payroll provider. When we contract with you, we integrate with Paychex to gain access to that live data stream to calculate the net earnings balance. The employee receives on-demand pay as requested. Through the employer integration, the books are automatically resolved on payday.

SANGEETHA RAGHUNATHAN (Earnin, Inc.):
We are opposed to S.B. 198. Earnin is a FinTech company with a direct-to-consumer on-demand pay product called Cash Out. Earnin has over 18,000 customers in Nevada and over 1.3 million customers nationally.

We are asking that S.B. 198 be strengthened to treat all on-demand pay providers equally and to include strong consumer protection provisions like fee caps, debit attempt limits and annual usage reporting requirements to FID, including transparency around how earnings are verified. Legislation should not be used as a tactic to pick winners and losers in an industry. We ask that Nevada treat all on-demand pay providers and consumers equally.

It should be noted that 67 percent of our customers, many of whom are small business employees, government workers and teachers, see fewer overdrafts when they start using Cash Out, and 66 percent are able to pay their bills on time more easily using our direct-to-consumer on-demand pay products. Earnin is not a lender, and our Cash Out product is not a loan. We only give people access to the amount of money that they have already earned.

People support Earnin voluntarily with tips. Our business model provides a no-cost, no-interest, no-fee option for workers to access their money when they need it and at a level that meets their budget.

While S.B. 198 is well-intentioned, it currently leaves out one-half of the on-demand pay industry and its consumers by excluding direct-to-consumer providers from being treated equally. In fact, the bill would consider

direct-to-consumer providers to be lenders, even though the employer-integrated and direct-to-consumers offer essentially the same service.

We believe that any bill that regulates on-demand pay providers should encompass the entire industry. The similarities between employer-integrated and direct-to-consumer providers are many. We both give people access only up to what they have already earned. We are both nonrecourse. We both provide workers access to third-party funds, based on the worker's accrued earnings. Regardless of whether the service is employer-integrated, the money advanced is never directly from the employer's payroll. Both business-to-business and business-to-consumer providers have authorization to debit the consumer's account for repayment.

The differences are few. Employer-integrated providers sign contracts with employers, while we have agreements directly with workers. We give workers the flexibility to take this tool with them no matter where they work, whether they are employed by a big corporation or the coffee shop down the street. Employer-integrated providers verify employee wages with the employer, whereas we verify via wage information such as timesheets and wage stubs, with the employee's explicit permission. Employer-integrated providers charge employers and customers for the service in the form of transaction fees. We accept voluntary tips from workers directly, if they choose, but always provide any worker the option to access their pay at entirely no cost. That includes no transaction fees.

Similar bills have been proposed in New Jersey, New York, Georgia and South Carolina and have not passed because of the unintended consequences of acknowledging only half of the on-demand pay industry and lacking basic consumer protection elements. We welcome the opportunity to speak with the bill's sponsor, Committee members and all stakeholders on this issue so we can ensure consumers, especially those employed by small businesses, are protected and provided with options to access their earnings in real-time.

PETER ALDOUS (Legal Aid Center of Southern Nevada):
We are neutral on S.B. 198.

We would like to thank Senator Cannizzaro for bringing this legislation, as it is important for the State to regulate this new and potentially helpful service. I appreciate the continuing dialogue we have had regarding this bill. For the most

part, I believe this bill will help low-income Nevadans by giving them a safer and less expensive option to meet unexpected expenses. I especially appreciate that the bill makes a distinction between employer-integrated and direct-to-consumer providers, since the relative risk to consumers is much lower in the employer-integrated model.

I have a few concerns with the bill that I hope can be addressed. I want to be sure the FID is able to effectively regulate providers, and I echo the concerns that they have raised previously. I am also concerned about language in section 17 regarding recourse in cases where the provider believes fraud has occurred. Unfortunately, financial institutions make mistakes, and I want to ensure the burden for resolving provider mistakes is borne by the provider rather than the users, who are already in financial distress.
I look forward to continuing the dialogue on this bill.

SANDY O'LAUGHLIN (Commissioner, Division of Financial Institutions, Department of Business and Industry):
We are neutral on this bill. The FID is currently working with stakeholders to establish stronger consumer protections to make this bill work for all.

SENATOR CANNIZZARO:
It is important for us to regulate this industry in a way that will ensure consumer protection. This practice is going on right now regardless of whether we step in or not. It is incumbent on us to take the initiative. If we can ensure consumer protections are built in, that is what we should be doing.

VICE CHAIR NEAL:
I will close the hearing on S.B. 198 and open the hearing on S.B. 229.

SENATE BILL 229: Revises provisions relating to the practice of pharmacy. (BDR 54-823)

SENATOR JULIA RATTI (Senatorial District No. 13):
I am excited to bring a bill that expands the role of an important part of our healthcare workforce: pharmacists.

The Covid-19 pandemic has exposed some weaknesses in our system of care. We have seen it in the disproportionate impact on people of color and other communities. We have seen it in the lack of public health infrastructure. We

have also seen it in a practice that we have in State law, the collaborative agreement, which allows us to get the maximum benefit out of the workforce of pharmacists. But when the pandemic hit and we had a dire need to deploy that workforce, the way the collaborative practice language was set up in statute did not allow for that to happen. Instead, we had to have emergency orders to allow pharmacists to work within their scope, to work at a level they have already been educated to, to work at a level State law acknowledged they can work. Unfortunately, some technical barriers in the law prevented it from happening.

I want to be very clear here. Collaborative practice agreements between pharmacists and physicians are already in State law. This bill is intended to remove some of the technical barriers that make it impossible for us to use that workforce in a way that is completely appropriate within their scope of work during the pandemic. This is important because once the emergency orders are lifted, we still have a huge issue in Nevada with access to care.

The Nevada Pharmacy Alliance and the Nevada Society of Health-System Pharmacists put together a flier (Exhibit G) titled "Utilizing Pharmacists" that explains the need for this measure. Nevada is still forty-fifth in the United States when it comes to access to health care. We know that there are many areas of the State that have a shortage of healthcare providers. There are just not enough practitioners. We are forty-eighth in the Nation in terms of primary care physicians per 100,000 population. At the same time, 90 percent of Nevadans live within five miles of a community pharmacy.

Pharmacies and pharmacists, by their nature, are neighborhood-based. They are some of our most accessible healthcare providers, and we underutilize them. Pharmacists have doctoral-level education; they have a well-defined scope of practice; and collaborative agreements allow them to work with physicians.

Let me give you an example. Let us say I come down with the symptoms of strep throat. I have a primary care provider, but it will take me several days to get to see that person. Under this bill, I could go to my pharmacy where my pharmacist can run a test, read that test and dispense the medication for strep throat. In this specific example, we know what drug to prescribe; we know that drug is not particularly dangerous; and we know that if we get it to you quickly you are likely to have a much better outcome. If all that can happen, I am going to have a significantly better health outcome than if I have to wait to get in to

see my doctor. It is going to be significantly more convenient for me, and my employer is going see me back at work more quickly. The downstream effects are significant. This is what we are looking to happen with S.B. 229.

When a pharmacist has an agreement with a physician, they agree on what, within the pharmacist's scope of practice, that pharmacist can do and how and under what strict protocols. The safety of the patient is maintained, and the patient gets access to health care. We have not broken the provider relationship; we are utilizing a professional who has the skills to get what we need in a convenient cost-effective location. That is the general idea.

The basic function of this bill is to remove a couple of barriers. First, it removes the language that says these collaborative agreements can only take place in a medical facility. Obviously, a grocery store with a pharmacy counter in it is not a medical facility. Existing law would prohibit the example I just gave from happening.

The bill also takes away the requirement that there has to be a referral. If I have to go to my doctor and that doctor has to refer me to a pharmacist, it takes away any savings in time and is not helpful.

The bill takes out another limitation that says the doctor and pharmacist have to be within 100 miles of each other. If we have learned anything in this pandemic, it is that we can maintain a significant relationship regardless of our distance from each other. There is no logical reason why that doctor and pharmacist need to be within 100 miles of each other.

The bill also takes away the requirement that the pharmacist has to tell the patient that the pharmacist is not a doctor. By consulting a pharmacist, the patient is consenting to being seen by a pharmacist. We think this is unnecessary, though we are open to conversation on this point. It just seems like more paperwork has to be generated every time there is a visit.

The bill clears up the definitions of what needs to be in the agreement between doctor and pharmacist so that everyone is on the same page. They both know what the pharmacist is allowed to do and under what conditions and under what rules and protocols.

BETH SLAMOWITZ, PHARMD (Senior Policy Advisor on Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services):
I will give a brief introduction to what a collaborative practice agreement is, for those who are unfamiliar with it, and then walk through the sections of S.B. 229.

A collaborative practice agreement creates a formal practice relationship between a pharmacist and other healthcare practitioners, whereby the pharmacist assumes responsibility for specific patient care functions. The extent of the services authorized under the agreement depends on the State's statutory and regulatory provisions for that authority, as well as the terms of the specific agreement between the pharmacist and the other healthcare practitioners.

In 2015, the National Governors Association presented the following state policy considerations in regards to collaborative practice provisions. They stated that states should:

• Enact broad collaborative practice provisions that allow for specific provider functions to be determined at the provider level rather than set in state statute or through regulation, and

• Evaluate practice setting and drug therapy restrictions to determine whether pharmacists and providers face disincentives that unnecessarily discourage collaborative arrangements.

Healthcare workforce is a critical component for a healthy Nevada. The intent of S.B. 229 is to remove current collaborative practice authority barriers that exist and increase the flexibility by defining elements that are more appropriately determined by the parties at the practice level who voluntarily enter into a collaborative practice agreement. It is in the interest of the State to encourage the use of collaborative arrangements between pharmacists and healthcare practitioners to expand, improve and provide access to care.

Section 1 of the bill amends *Nevada Revised Statutes* (NRS) 639.0124 to remove the requirement that the development of written guidelines and protocols in collaboration with a practitioner are intended for a patient in a licensed medical facility or in a setting that is affiliated with a medical facility where a patient is receiving care. A pharmacist's practice setting or a patient's

relationship with a medical facility should not be a barrier to the pharmacists and practitioners' ability to enter into a collaborative practice agreement.

Section 2, subsection 2, amends NRS 639.2623 and removes the barriers for a practitioner to enter into a collaborative practice agreement which includes the requirement for a patient referral by a practitioner to a pharmacist, the requirement for the practitioner to obtain an informed written consent from a patient who is referred and the requirement that the practitioner practice his or her profession within 100 miles of the primary location where the collaborating pharmacist practices in this State. Pharmacists and practitioners may specify the level of patient involvement in the collaborative agreement. Depending on the level of service, elements such as informed consent, written consent or opt-out provisions may be appropriate, as determined by the parties to the agreement.

Section 2, subsection 3 of the bill adds language that a collaborative practice agreement does not grant a pharmacist the authority to engage in an activity that is outside the scope of practice of the collaborating practitioner.

Section 2, subsection 4 of the bill maintains the current language that outlines the requirements of a pharmacist who engages in a collaborative practice agreement. These requirements include:

• Documentation of any treatment or care.

• Documentation of any decision or action concerning the management of drug therapy.

• Maintaining records concerning the care or treatment provided for at least seven years.

• Requirement to comply with all the provisions of HIPAA.

• Requirement to provide a patient with written notification of any test administered and the results, any drug or prescription filled and dispensed, and the contact information of the pharmacist.

Removing this language intends to remove the barriers of elements that may be determined at the practitioner level through the individual collaborative practice

agreements. Language to be removed includes the requirement for a pharmacist to obtain the informed written consent of a patient which must include a statement that the pharmacist:

• May initiate, modify or discontinue the medication of a patient.

• Is not a physician, osteopathic physician, advanced practice registered nurse or physician assistant, and

• May not diagnose.

Lastly, the bill removes the requirement that a practitioner may not enter into a collaborative practice agreement with a pharmacist for the management of controlled substances. It is recommended that all prescription drugs, including controlled substances, may be included within a pharmacists' collaborative practice authority.

Section 3 of the bill refers to NRS 639.2627. The language in section 3, subsection 1, paragraphs (a) through (j) is maintained and defines what must be included in a collaborative practice agreement as the following:

• A description of the types of decisions concerning the management of drug therapy that a pharmacist is authorized to make.

• A detailed explanation of the procedures that a pharmacist must follow, including documentation and requirement to report such decisions to the practitioner and receive feedback.

• Procedure by which a pharmacist will notify the practitioner of an adverse event.

• Procedure by which a practitioner will provide the pharmacist with a diagnosis and any other medical information necessary.

• A description of the means by which the practitioner will monitor clinical outcomes and intercede when necessary.

• Authorization for the practitioner to override the agreement.

• Authorization for either party to terminate the agreement.

• The effective date of the agreement.

• The date by which a review must be conducted for the renewal of the agreement.

Section 3, subsection 1, paragraph (k) is removed, which requires the inclusion in the agreement of the process by which the pharmacist will obtain informed, written consent.

Section 4 of the bill amends NRS 639.2629 by removing subsection 1, paragraphs (a) through (c) and replacing it with language which defines what must be included within the written guidelines and protocols developed by a pharmacist in collaboration with a practitioner which authorize collaborative drug therapy management. Language removed includes:

• Provision for collaborative drug therapy management for a patient receiving care in a licensed medical facility, or

• If developed to ensure continuity of care for a patient in a setting affiliated with a medical facility.

• Requirement for a pharmacist initiating or modifying drug therapy in a setting mentioned, to provide written notice within 72 hours to the collaborating practitioner or enter it into an electronic patient record system shared by the pharmacist and practitioner.

• Requirement to state the conditions under which a prescription may be changed by a pharmacist without a subsequent prescription from the practitioner.

The amended language requires the following to be included without limitation within the written guidelines and protocols:

• A description of the types of decisions that a pharmacist can make regarding the management of drug therapy including description of diseases, drugs or drug classes to be covered, and the types of decisions the pharmacist can make regarding the diseases, drugs or drug classes.

• The training the pharmacist is required to complete.

• The procedures the pharmacist is required to follow to make changes to drug therapy or other therapeutic decisions. Included would be the criteria to make those decisions and procedures for documenting and reporting those decisions to the practitioner.

• Procedures for the practitioner to provide feedback to the pharmacist.

Section 4, subsection 2 requires that the Board of Pharmacy approve any modifications to the written guidelines established by subsection 1.

Section 5 of the bill amends NRS 441A.110 to include a pharmacist within the definition of "Provider of health care."

Section 6 of the bill amends NRS 453.026 and defines an "Agent" as a pharmacist who cares for a patient of a prescribing practitioner, removing the language regarding "in a medical facility or in a setting that is affiliated with a medical facility."

SENATOR PICKARD:
This is well outside my wheelhouse. I do have a few questions that come from a legal perspective. As I understand it, we are talking about an agreement between a particular physician and a particular pharmacist, rather than a physician and a pharmacy like CVS or Walgreens. Is that right?

DR. SLAMOWITZ:
A collaborative practice agreement can be between a physician and a pharmacist or pharmacists. In a retail setting, collaborative practice agreements can name a number of pharmacists or the pharmacy itself. It can work either way, whichever is defined in the protocol.

YENH LONG (State Board of Pharmacy):
Existing law does allow collaboration between one or more physicians and one or more pharmacists to collaborate and allow an authorized pharmacist to manage medications.

SENATOR PICKARD:
I was thinking in terms of practical matters. If there are drug reactions that need to be watched for, pharmacies are busy operations. Every time I go to CVS or another pharmacy, they are scrambling to get everybody helped.

Since we are now adding diagnosis and treatment, I want to make sure I understand the legal structure we are talking about. Senator Ratti, you mentioned that we are eliminating informed consent. As a lawyer, I balk at that. It is not because it is not cumbersome; it certainly is that. But I would suggest we might want to talk to the legal eagles on this, because informed consent or lack of informed consent could open the pharmacy to some legal liability. I do not know the extent of that; this is not my area of expertise. I just wanted to toss that out.

DR. SLAMOWITZ:
The bill will not eliminate informed consent. That can still happen within the agreement between the practitioners as to what they are comfortable with.

We need to be clear that these agreements are voluntary. I do not think you are going to see every Walgreens and CVS jump into the arena. It is going to be based on capacity, willingness, opportunity and whether it makes sense for that community. In rural settings, it is a huge opportunity for them to work with physicians who are a hundred miles away or more.

In many states, community pharmacies are not doing complicated drug therapy types of management. It usually involves point-of-care testing, something pharmacists are already allowed to do in Nevada. The roadblock here is that under NRS, pharmacists are allowed to take specimens, but they are not allowed to read or respond to a test unless it is under a collaborative practice agreement. Because that does not currently occur in a retail setting, simple point-of-care testing, such as a strep test or a rapid influenza diagnostic test (RIDT), cannot occur.

SENATOR PICKARD:
I was talking about informed consent between the pharmacist and the patient. The patient needs to know that the pharmacist is not a doctor and is not necessarily trained to do everything a doctor would do. If we were to curtail that informed consent, it might open up the pharmacist to legal liability.

SENATOR RATTI:
We are open to an amendment that leaves the informed consent piece in place. It is not the critical provision in this bill.

We are spending a lot of time and energy talking about the retail environment. That is important. For the RIDT that gets you the antiviral medication you need within 48 hours, it is ideal. But these agreements also could be used in an cancer clinic or an HIV clinic with a specific pharmacist trained specifically to deal with that. That collaborative agreement is going to include a significantly different list of things the pharmacist can do than you might see in a Walgreens agreement, which might be strep and flu only.

That is why it is so important that the details end up in the collaborative agreement and not in NRS, where we end up trying to micromanage the relationship between a pharmacist, a doctor and a patient. The agreement between the pharmacist and the physician is critically important because it allows us to do things particularly in rural Nevada, where folks are having to drive significant distances because of the limitations we put in place.

SENATOR HARDY:
What we are talking about is allowing a pharmacist to practice the art and science of medicine independently, albeit covered by a collaborative agreement with a physician, when the physician is nowhere near.

Using the example of a strep test, one of the reasons we treat strep throat is to prevent rheumatic fever. The pharmacist does not have a stethoscope and is not trained to discern a heart murmur. Documenting the patient's condition before and after treatment becomes an issue. It is easy to say the pharmacist can do a simple test and give a simple treatment. That is good when it works, except when it goes south.

The obvious question for the physician is who has the liability. The physician obviously would have the deeper pockets, I would imagine, unless the pharmacist is working for CVS, and then CVS has deeper pockets than anybody else.

How many pharmacists can one doctor have a collaborative agreement with? Is there one doctor in Clark County, for instance, who can take all the pharmacists in CVS?

DR. PORATH:
Under existing law, each individual pharmacist and physician have to be listed in the agreement. That has been a barrier in the community pharmacy setting.

Regarding liability, Senator Hardy is correct. Everything is done ultimately under the authority of the physician. While all pharmacists involved in collaborative practice work are encouraged to have individual liability coverage, in most cases with collaborative practice agreements, the physician has the deep pockets.

SENATOR RATTI:
Just to be clear on this point, we think that is a good thing. If liability is part of the equation, folks will enter into collaborative practice agreements that are well backed up by scope of practice and research that only generally safe procedures and treatments will be allowed. We do not want wholesale collaborative agreements that are going to open up significant risk for patients. We want thoughtful, conscientious practitioners, both physicians and pharmacists, making thoughtful decisions about how to get patients care.

SENATOR HARDY:
I did not hear an answer to my question as to a limit to the number of pharmacists one physician can cover. Doctors have physician assistants, and we limit how many physician assistants each doctor can have.

SENATOR RATTI:
There is no limit in NRS because it depends on what is in the collaborative practice agreement. Going back to the flu example, you might have one physician for lots of pharmacists in a retail setting where we are comfortable with the ability to take an RIDT and then to issue a prescription for flu. We clearly would not have that same comfort levels if we are talking about controlled substances in a cancer pain management clinic, where there is going to be a much tighter relationship between a physician and a pharmacist who is working in that kind of collaborative agreement.

Those limits get defined in the practice agreement based on the agreement between the physician and the pharmacist. Those two professionals make that decision within that agreement.

SENATOR HARDY:
What is the motivation for the physician to take on this liability? The physician has no control over what happens day to day in a collaborative agreement. Is there a sharing of the fee? Is there an employment agreement? What would motivate the physician to take on liability that the physician has little control over?

SENATOR RATTI:
I want to emphasize again that collaborative practice agreements are already in place in Nevada with no limits. The market is tested, and there is enough motivation that these already exist. This bill is just removing some barriers.

DR. PORATH:
In my experience, most of these arrangements have the pharmacists operating as employees of either a pharmacy or a healthcare facility. A monetary relationship between the physician and the pharmacist typically does not exist. The motivation from the physician's perspective is several fold. First, they are increasing access to care for their patients. The pharmacist can see them in between physician visits.

In my practice, I deal with a lot of cardiovascular disease, diabetes, high blood pressure and so on. When we have patients who are struggling with those disease states, the physicians are not necessarily able to see them as often as the pharmacist can to check blood pressure and adjust medications. It is a matter of access. The evidence supports the idea that co-management between a pharmacist and a physician improves outcomes across the board, especially with chronic disease states. It is proven in blood pressure and diabetes. That is the motivation: to improve care.

SENATOR HARDY:
In the interest of time, I will take the rest of my questions offline.

SENATOR NEAL:
What is going to be the compensation structure for the pharmacist in a retail structure? Typically, clinical service is rolled into their salary. They are not allowed to use their provider identifier number or establish themselves outside of the retail pharmacy's space. This is additional work.

DR. PORATH:
In most collaborative practice agreements, the financial arrangement is that the facility the pharmacist works for collects the evaluation and management charges. The pharmacist is an employee of that facility. There is no real financial incentive for the pharmacist to get involved in this work.

When we talk about how this would work in a retail setting, there has to be a transition of the expectations of the community pharmacist to move away from producing a certain number of prescriptions an hour to this other value-based activity. Otherwise, what incentive would there be for Walgreens to have their pharmacist involved in this work? If they are not filling prescriptions, they are not making money.

In the scenario we are talking about with a community pharmacy, these point-of-care tests are revenue-generating activity. Without direct remuneration for the clinical services a pharmacist provides, there is no mechanism in this bill for that to exist. That would have to be negotiated with payers. It has been an ongoing struggle for me, I can tell you.

SENATOR NEAL:
I am glad you brought that up. I would like to talk with you about that offline. At the end of the day, pharmacists earned their degrees and their credentials. If they are going to engage in this practice in this retail environment, that incentive matters. It matters one hell of a lot. This is their time and expertise being used, and they are not being compensated in that structure.

ELIZABETH MACMENAMIN (Retail Association of Nevada):
I want to add to what Dr. Porath said. In other states, this practice has been ongoing. I will talk to some of our national branches and find out how this works in states where it has been implemented. We have had some roadblocks in Nevada in the past to expanding the community pharmacy to provide these types of services. I will work with you offline, and we will find out how compensation works for the pharmacist in those settings.

SENATOR RATTI:
I do not think we can get to the compensation structure until we eliminate the barriers in NRS. There are so many barriers in NRS now that you could not build a model that would make sense for any of the parties. To be able to use this

group of professionals to the top of their education, we need to remove those NRS barriers to make the collaborative practice agreement work.

NICK VANDER POEL (Reno + Sparks Chamber of Commerce):
We support S.B. 229. This bill expands access to health care for Nevadans, especially in rural Nevada. We know there is a doctor shortage in Nevada, so this bill will fill a much-needed gap in services. During the pandemic, pharmacists played an essential role. This bill allows them to continue serving Nevadans in an even more needed role. We appreciate Senator Ratti for bringing this bill and urge your support.

DR. GUPTA:
The Nevada Pharmacy Alliance fully supports S.B. 229.

As part of my clinical responsibilities, I provide direct patient care to a medically complex underserved population. I optimize the use of medications for chronic diseases to ensure efficacy while limiting adverse effects and misuse in collaboration with primary care providers. The providers I work with will attest that I am a valuable part of the healthcare team, helping to improve care through medication management. This is especially true for disease states such as diabetes that are mostly managed through complex groups of medications and require significant education.

No other healthcare providers receive four years of a doctoral education primarily focused on the management of diseases using medications. I am knowledgeable about the 30 different types of insulin available on the market, and, often more so than the primary care providers, I am aware of which ones are most likely to be covered by the patient's insurance. However, most community health centers and primary care offices do not have a clinical pharmacist to provide these services. Most pharmacists are located in community pharmacies, and the current restrictions in implementing a collaborative practice agreement in a pharmacy limit the provision of care and make it impossible for a pharmacist to provide these services. For example, if a patient is experiencing low blood sugar, the community pharmacist has the knowledge to determine which of the five diabetes medications the patient is taking is most likely to cause low blood sugar. Rather than the patient stopping some or all of their diabetes medications on their own because of the scary side effects and waiting for an appointment with the primary care provider three months from now, the patient can have the discussion with the

pharmacist when picking up medications on at least a monthly basis and make modifications to avoid a gap in therapy.

This bill allows for appropriate loosening of those restrictions so that unnecessary requirements do not hinder pharmacists from using their medication expertise to expand access to health care for Nevadans. I want to emphasize that pharmacists are still acting within their scope of practice and still in collaboration with practitioners, and those roles are clearly delineated within the collaborative practice agreement.

Nevada is ranked forty-eighth in the Nation for primary care physician access. Allowing pharmacists to practice effectively within their scope of knowledge and abilities will increase access to care and ultimately reduce healthcare burden and costs.

KRYSTAL RICCIO:
I am a 22-year resident of Nevada, an associate professor of pharmacy practice with Roseman University of Health Sciences, and one of the few primary care pharmacists in Nevada. Today I am speaking personally in support of S.B. 229, increasing access to care for Nevadans in rural, frontier and urban communities.

Many residents live in a desert, both a literal desert and a medical desert. Nevada has a disparate shortage in primary care physicians, and this bill is a step in the right direction to increase access to medical care. Medical providers have promoted the concept of team-based care for years, with pharmacists as an essential part of an effective care team. Physicians are given extensive education and training in physical assessment and diagnosis, while pharmacists receive years of education and training in providing medication therapy management.

I have worked collaboratively with physician groups for over a decade to provide optimized care for our patients as a significant part of our care team, providing extensive education in chronic disease management within the scope of my practice. I am board-certified as an ambulatory care pharmacist, and after thousands of hours of practice, I am also certified as a diabetes care and education specialist. Despite years of practice, developing rapport and trust with my patients and physicians, barriers in our past and present legislation hinder my pursuit of formal collaborative practice agreements in Nevada.

Unfortunately, practice without a collaborative practice agreement creates its own barriers, requiring physicians to be on site during all of my patient encounters and requiring me to interrupt the physician's practice day to get approval for any medication changes I am recommending. This has caused me to cancel patient appointments due to physician illness, physician off-site meetings, or other last-minute physician schedule changes. We avoided pursuing a collaborative practice agreement due to the cumbersome process required for the initial approval, consistent amendments based on frequent guideline and medication changes, and the annual renewal process through the Nevada Board of Pharmacy.

This bill will open up opportunities to streamline the process and allow the trust between a pharmacist and a practitioner collaboration to provide improved access to care for Nevadans.

I strongly support S.B. 229.

AMY HALE (Nevada Pharmacy Alliance):
I am a clinical pharmacist for OptumCare Cancer Care in Las Vegas. I would like to voice my support for S.B. 229.

I previously worked under a collaborative practice agreement, but we let it lapse due to many difficulties, including delays in reapproval of the agreement if we wanted to adjust the language or any of our pharmacists provided services. I have the full support of all the physicians with whom I work, and they all signed the previous collaborative practice agreement.

Patients with kidney problems see a nephrologist; patients with cancer see an oncologist. It makes sense that we as medication experts should manage a patient's medication therapy after a provider has made a diagnosis. Our training is similar to a physician's, but it is focused on medication. We complete a significant number of clinical training hours in school, and many of us, especially those of us who work in specialty areas in hospitals and outpatient clinics, complete residencies and hold board certification just like physicians do. Most physicians who trained with clinical pharmacists will also speak to how they use pharmacists to make patient care decisions, and they still consult pharmacists when they encounter difficult patient cases and recognize us as critical members of an interdisciplinary healthcare team.

One issue we encountered after the dissolution of my collaborative practice agreement was an increased burden on providers. They had relied on me to make appropriate dosing adjustments per our protocols, adjust supportive care per peer-reviewed and evidence-based guidelines, interchange drug products per our internal formulary, and follow up on tests and labs needed for specific medications. Now they must be repeatedly interrupted throughout the day to implement these changes that they feel are well within the scope of practice of a trusted pharmacist, or they would not have signed the original agreement. My day usually ends with a number of providers in my office. We discuss the patients they saw during the day, and they ask for my opinion on how to proceed in their cancer therapies. In an assessment of the value of a clinical pharmacist in our clinic, I have a 97 percent acceptance rate for my recommendations to our physicians.

I hesitate to address this piece because I recognize the importance of it, but my physicians did question my need to request an informed consent from our patients. This required our providers to know which patient required closer attention from them because they could not rely on those pharmacist interventions to happen independently. They also stated that our nurse practitioners are not required to obtain an additional informed consent before those nurse practitioners see a physician's patients, nor are patients required to sign an informed consent to have pharmacists call a physician on a patient's behalf in a retail setting.

In summary, removing barriers to collaborative practice agreements allows for more comprehensive healthcare teams and greater communication between physicians and pharmacists. It can reduce delays in care by having a pharmacist immediately resolve issues with medication. It can augment the patient-physician relationship by having more trained eyes evaluate a patient's therapy, resulting in better controlled healthcare costs. This has been shown in a number of studies. In my clinic alone, we showed a reduction of $20,000 in a single month by reducing unnecessary prescribing simply through pharmacist intervention.

PAUL J. MORADKHAN (Vegas Chamber):
We are in support of S.B. 229. As you have heard, this bill will be another tool in expanding access to health care and convenience for Nevadans. As we continue to work to address the doctor shortage throughout Nevada, this bill will help us in the short-term for the benefit of patients. This bill will allow for

greater efficiency and utilization within the healthcare delivery system in Nevada.

DR. KUNKE:
The Nevada Pharmacy Alliance is excited to expand our ability to take care of patients, and I am here to show our support for S.B. 229. Since the pharmacy collaborative practice agreement bill passed, it has been difficult for pharmacists to put it into action. In May 2020, we sent out a survey to 14 pharmacists who were working inside clinics. All 14 responded, but only 5 reported they were currently working under a collaborative practice agreement. As we talked to them, it became clear that the current law is stopping them from entering into collaborative practice agreements and being able to truly be part of the healthcare team.

Currently, 48 states have collaborative practice agreement laws. Some are very restrictive, like ours, but others allow pharmacists to truly use the skills they learned in school to treat patients to the best of their ability. You may be wondering how providers and pharmacists enter into these agreements. In 2016, a resource called "Advancing Team-Based Care Through Collaborative Practice Agreements" was created. It is endorsed by many organizations including the Centers for Disease Control, the American Association of Nurse Practitioners and the American Medical Association. I would encourage you to look into this document.

Earlier, you heard some scary numbers regarding access to care for patients in Nevada. You also heard examples of how this bill would open up access. We have 2,470 licensed pharmacists who are ready to step up and help our patients. I am asking you to please show your support for S.B. 229.

MS. BOWMAN:
I am here as a licensed pharmacist in Nevada for 14 years. I have practiced in multiple settings, including community and hospital pharmacies and neighborhood and medical clinics. Currently, I am the clinical pharmacist at Roseman Medical Group, working collaboratively with the providers as part of a team-based care model. This collaboration was the result of six months of meetings, clinical service contract negotiations and approval to work outside of a licensed pharmacy from the Nevada State Board of Pharmacy.

I do not have a collaborative practice agreement in place at this time. However, I plan to pursue this in the near future. That is why this legislation is important to me. Progressing to a collaborative practice agreement is the next step based on the trust built within the clinic setting between myself and other providers. The collaborative practice agreement process requiring approval by State or legislative boards is a concern to me since it may result in increased approval time and the burden of added paperwork. Allowing the pharmacists and providers to complete the collaborative practice agreement will allow for timely implementation of expanded care for patient access and improved patient health and wellness. As a member of the healthcare team, I have increased patient awareness of medication adherence, further supported behavior changes and taught self-management of chronic disease and illness. Having a collaborative practice agreement will maximize my role as a pharmacist and utilize my skills to my fullest ability and training.

There is more to being a pharmacist beyond the dispensing of medication. I have been an immunizing pharmacist since 2005 when I was still a pharmacy student intern. I provide drug information and initiate naloxone therapy. I have been trained as a lifestyle coach for patients with diabetes, high blood pressure, high cholesterol, smoking cessation, nutrition and weight management. I provide medication therapy management services, chronic disease monitoring and education, all of which are within my scope of practice and per existing state protocol. So how will this collaborative practice agreement legislation make it different? I will be able to collaborate more efficiently and effectively with the team care members, improve healthcare outcomes for our patients, and thus build healthier communities in Nevada.

That is why I am asking you to show your support for S.B. 229.

JoAnn Malay (Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
We are neutral on this bill.

We believe S.B. 229 creates flexibility in these collaborative drug therapy management agreements. Pharmacists become part of the treatment team by working directly with patients to manage disease and can help reduce costs in medication management. This bill also allows pharmacists to perform point-of-care testing, which may impact how the access for testing of Covid-19 may expand.

SENATOR RATTI:
This bill has been a personal mission of mine since I have had the privilege to be elected to this office to increase access to health care. We do not have many tools we can use, and when we do have a tool, we should use it. We have 2,470 pharmacists who are ready to step up and step into the roles they are already educated for, roles that are part of their scope of practice, in collaboration with physicians across Nevada. There are already collaborative practice agreement laws in place; we just have a few barriers to remove to make them effective.

CHAIR SPEARMAN:
I will close the hearing on S.B. 229. Is there any public comment? Hearing none, we are adjourned at 11:01 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 190	B	1	Caroline Mello Roberson / NARAL Pro-Choice Nevada	Letter of Support
S.B. 190	C	1	Marcos Lopez / Americans for Prosperity	Written Testimony
S.B. 190	D	1	Ken Kunke / Nevada Pharmacy Alliance	"Pharmacists Expanding Nevadans' Access to Care"
S.B. 198	E	1	Senator Nicole Cannizzaro	Industry Background Information
S.B. 198	F	1	Senator Nicole Cannizzaro	Conceptual Amendment from Alisa Nave-Worth of DailyPay
S.B. 229	G	1	Senator Julie Ratti	"Utilizing Pharmacists" flier from Ken Kunke