MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
May 15, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:03 a.m. on Monday, May 15, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Roberta Lange, Vice Chair
Senator Melanie Scheible
Senator Skip Daly
Senator Julie Pazina
Senator Scott Hammond
Senator Carrie A. Buck
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Assemblywoman Venicia Considine, Assembly District No.18

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bryan Fernley, Counsel
Veda Wooley, Counsel
Kelly K. Clark, Committee Secretary

OTHERS PRESENT:

Kate Marshall, Hopewell Fund
Annette Magnus, Battle Born Progress
Chris Daly, Nevada State Education Association
Tess Opferman, Nevada Women's Lobby
Kent Ervin, Nevada Faculty Alliance

Maria Moore, State Director, AARP Nevada
Ariel Guevara
Cyrus Hojjaty
Eric Jeng, Nevada Asian American and Pacific Islander Chamber of Commerce
Briana Escamilla, Planned Parenthood Votes Nevada
Unidentified Testifier
Marlene Lockard, Service Employees International Union Local 1107
Matthew Wilkie
Danny Thompson, Pharmaceutical Industry Labor-Management Association
Dharia McGrew, Ph.D., Pharmaceutical Research and Manufacturers of America
Jimmy Lau, Biotechnology Innovation Organization
Amy Shogren, Nevada Hospital Association
Adam Porath, PharmD, Nevada Society of Health System Pharmacists
Liz MacMenamin, Retail Association of Nevada
Tom McCoy, Nevada Chronic Care Collaborative
Paul Moradkhan, Vegas Chamber
Emily Osterberg, Henderson Chamber of Commerce
KayLynn Bowman, PharmD, Nevada Pharmacy Alliance
Wiselet Rouzard, Americans for Prosperity Nevada
Leah Lindahl, Healthcare Distribution Alliance
Jarrett Clark
Jamie Cogburn, Nevada Justice Association
Helen Foley, Nevada Association of Health Plans
Tray Abney, America's Health Insurance Plans

CHAIR SPEARMAN:
Welcome Assemblywoman Considine and Lieutenant Governor, this is an honor. We will start with Assembly Bill (A.B.) 250.

ASSEMBLY BILL 250 (1st Reprint): Establishes provisions governing prescription drugs. (BDR 40-782)

ASSEMBLYWOMAN VENICIA CONSIDINE (Assembly District No. 18):
I will be presenting A.B. 250. I have former Lieutenant Governor Kate Marshall here to help me present the bill. She is a senior advisor with the Hopewell Fund's Impact Project. She was a special advisor to the White House.

This bill is about people who have life-altering and life-changing health issues who are often unable to afford their prescriptions. Sometimes they do not take

the full dosage. They cut pills in half or skip them altogether even when they have a serious health issue that requires a daily dosage.

This bill is about providing relief to certain Nevadans who are facing those financial issues. Most of us have dealt with serious health issues, either for ourselves or our family members. The point of this bill is to provide prescription drug relief to Nevadans.

I have had numerous conversations with stakeholders about this bill. I have listened to their worries. As I thought about this bill over the weekend, I realized many of those conversations had a magical effect, almost a sleight of hand, on my perceptions.

I am bringing this bill to provide relief to people. But what I hear in talking with stakeholders and the industry is that this bill will end private research and development (R&D).

I also hear from industry, "If you do this, we will just have to charge more for other things." That is the definition of cost-shifting. They say we should fix the system first, but do not fix it now because there is too much going on.

The blame goes on. It is not us; it is them. It is the fault of the pharmacy benefits manager (PBM). It is the insurance company. The blame goes back and forth.

The prescription drug companies say, "If you do this, we will lose profits." I find that interesting because drug companies are reporting record earnings, yet they are still raising prices on the drugs Americans need to survive.

Reuters reported that five of the largest drug companies in the world will increase the prices of more than 350 drugs in 2023 alone. Over the weekend, I read a piece in *The New York Times* that prescription drugs on average cost two and a half times more here inside the U.S. than they do outside the Country.

The article also talked about some of the pharmaceutical giants, often referred to as Big Pharma, assigning patents and other forms of intellectual properties to overseas subsidiaries to game the U.S. tax system. The companies essentially credit their profits to a lower tax jurisdiction, making the profits disappear here and reappear in those lower tax jurisdictions.

What I rarely hear is "How do we help the people who cannot afford their prescriptions?" That is what A.B. 250 does.

Before I explain the mechanics of the bill, I would like to ask Ms. Marshall to talk about her own experience facing a life-altering health situation and having to balance her family's needs with the cost of these lifesaving drugs.

KATE MARSHALL (Hopewell Fund):
I do not normally explain my personal life and share my medical issues. But Assemblywoman Considine had the opportunity to hear about it. She asked if I might tell you about my experience with how a family thinks about and deals with health costs.

In 2016, I was diagnosed with cancer. Perhaps because of my age, I assumed it was a death sentence. It was not, as you can see. We have a lot of opportunities and therapies available to us.

The cancer had advanced, and I needed to get into surgery immediately. It was Easter when I got the diagnosis, and it was Mother's Day when I went into surgery. By the time I got out of surgery, we had hit our annual insurance cap. That was not the first time I hit the annual cap.

When I got out of surgery, I was told that I would need chemotherapy. However, there was a company in California that could test the DNA of the tumor and provide a ranking between 1 and 100. If the ranking was below 18, I would not need chemotherapy. However, that DNA testing of the tumor was not covered by insurance.

One of the things to understand is that when you reach your annual insurance cap, depending on your insurance, it can be 80/20 or 70/30 that you continue to pay, unless it is not covered by insurance.

The cost for the DNA tumor test was $8,000. Mind you, we had already hit our annual cap. We were quickly cleaning out our savings. I called the DNA testing company. I did not know what to do in this situation. Do you put the charge on your credit card? Do you tell your husband? Do you tell him later, after you get the results?

I was worried. I sat down with my husband. I said, "I think we need to divorce so that you can have the house." He said, "No, I do not think that they take the

house anymore." That was not the first instance. We came up with the funding for the test. My DNA number was 17. That was a life-changing diagnosis. It meant I did not have to get chemotherapy, but I did have to take medication.

The first medication I took turned me into a ball. I would wake up in the morning. I would have to unfurl myself and literally pull myself up the stairs. I asked the oncologist if there was another medication. Is this what I have to take for five years? Is there a different one? The answer was that there are some other drugs, but pretty soon you are going to get to ones that are not covered by insurance.

Then, because you are taking this medication, you go to the oncologist's office, and they tell you to go to the billing department first. By then, I had hit my annual cap a second time. I was told, "You do not get to see the oncologist; go to billing first."

I went to billing. They told me that I needed some other drug so that I would not get osteoporosis because the drugs I was taking accelerated bone loss, but that osteoporosis medication is not covered by insurance. I do not have to take it. I was sitting there thinking, "I want to survive the cancer, but I do not want to then break a hip." How do you balance these decisions? What I wanted to say was, "Okay, I will take that medication."

I am sorry, I get a little emotional. But you are going to hear from a lot of people about a lot of things. At the end of the day, this bill is about someone who was sent to the billing department who needed medication.

There is no competition for that medication. Can we please begin the process of bringing down prices for people? I was not 65 years old; I do not have Medicare. I had the State's health care plan. It is a good plan.

ASSEMBLYWOMAN CONSIDINE:
This bill is designed to reduce the costs of certain high-cost, noncompetitive, life-changing prescription drugs by extending the benefits of the federally negotiated Medicare drug prices that were made possible under the Inflation Reduction Act of 2022 (IRA) enacted by the 117th United States Congress.

Under A.B. 250, this benefit would be extended to all Nevadans, whether you are 59 years old and facing breast cancer, 65 years old and already on Medicare, or 14 years old with a disease that requires one of these drugs to

make you healthy. You would all pay the maximum fair price (MFP) federally negotiated for Medicare.

The federal IRA required that pharmaceutical companies work with Medicare to determine the MFP. Before the IRA, it was unlawful to negotiate drug prices in this Country. The fact that Medicare and the pharmacy companies will negotiate MFPs for up to 50 life-altering noncompetitive drugs is why we are sitting here today. The first ten drugs that may be negotiated are on the list we have provided (Exhibit C).

I will give you an idea of what these drugs can cover. We do not know for sure if these will be the ten selected for negotiation. The goal is to negotiate first on the highest use drugs with the highest cost to Medicare, the drugs without competition.

Of the 50 prescription drugs originally selected, 10 drugs will have new pricing go into effect in 2026. We have provided you a timeline (Exhibit D) for price negotiations. The first ten drugs will be determined by September 2023; the prices will then be negotiated by September 2024; and the MFP will go into effect in January 2026.

Nevada Senator Catherine Cortez Masto and Minnesota Senator Amy Klobuchar have a bill in the U.S. Senate right now to speed up that timeline. I do not know where that will go, but that is what they are working on.

Once those ten drugs are determined, we would like to have the infrastructure in place here in Nevada so if you are on Medicare, you will automatically get that MFP. If you are not on Medicare and your doctor has prescribed these drugs for your life-altering health issue, you would only pay the MFP.

If your insurance company has worked out a lower price with the PBM than the negotiated MFP, you retain the benefit of that lower price. We are not changing anything that has been negotiated to a lower price. That is essentially what this bill does. Approximately 565,000 Nevada seniors, about 17 percent of the State's population, are enrolled in Medicare. Those seniors will soon enjoy the benefits of these negotiated prices.

In 2027, the IRA will allow 15 more drugs to have the prices renegotiated, then 15 more the following year, potentially renegotiating pricing for all 50 listed drugs. This will be a rolling list of prescription drugs that are without

competition; they have had their pricing negotiated at the national level to establish the MFP ceiling.

For seniors on Medicare, this will be great. But unless A.B. 250 passes, the rest of us in the State will be left paying the full amount that the pharmaceutical companies, PBMs and insurance companies can charge. Those life-changing medications we need will be out of reach.

It will cause people to have kitchen table discussions about whether to keep the house, save for the education of their children or invest in a family member's health at the expense of the rest of the family.

But A.B. 250 can change that by applying the negotiated prices of pharmaceutical drugs under this Medicare system to Nevadans who need them.

I will go over the bill. I have provided an amendment (Exhibit E) to remove section 1, subsection 8, which I will talk about later.

A person or entity that purchases a drug referenced on this list in Nevada shall not pay a price higher than its MFP during the price applicability period. This excludes any fee paid to the pharmacy for dispensing the referenced drug.

Essentially, this means that any person who purchases a referenced prescription drug at a pharmacy will pay a lower negotiated price. If they do not have one that is lower, they will pay the MFP for that prescription.

This bill does not touch the pharmacy, doctor or physician's fees, or the pharmacy dispensing fees. We are not touching those; this bill only affects the cost of the drug.

If the consumer does pay a price that is higher, then the entity that sold it is in breach of a deceptive trade practice. There is a private right of action to enforce that. Also, these drugs are only this price during the price applicability period.

If for some reason a drug falls off this Medicare-negotiated list, Nevada will do that as well. The definitions for maximum fair price and other definitions are already in the bill, so I will not go over them.

Essentially, this bill provides relief. Our initial draft of this bill provided relief to everyone. We had an amendment that took the unions out and allowed them to

opt in. However, further discussion with the unions has supported putting that section back in, so A.B. 250 does cover every Nevadan for these drugs.

SENATOR DALY:
I will comment first on the language you removed regarding the Employee Retirement Income Security Act (ERISA) of 1974. My understanding is that under the IRA, which allows the government to now negotiate for prescription prices, the ERISA plans would not be exempt anyway. It makes sense to remove language that would potentially conflict.

I have gone back and forth on this particular bill. Thanks for the personal story. You are right, we do not know what will happen. We do not know which drugs are going to be on the list. There are a lot of moving parts.

People are familiar with the bell curve. If you price something at 30 percent and 70 percent, you collect the same amount of money. For these drugs with no competition, the current approach is to deal with drugs in high demand and maximize profit.

If there is an opportunity to get these drugs into a formulary on many different plans, that may increase the volume of sales. Nobody knows for sure how that will work out. But the government is moving toward that. When we negotiate preferred provider contracts, we are setting the reimbursement rate so we can attract providers. Our people can get treatment at Medicare pricing plus a percentage.

That is just the way the system works; it is a for-profit system, and we all must deal with it. I am not saying this is necessarily a bad idea, but time will tell if it is really going to work.

Either way, the federal government is going to negotiate prices for the first ten drugs, and then the next ten drugs. It is going to create more opportunity than harm and everybody will adjust from there. I thank our former Lieutenant Governor. I spoke to her over the weekend. I have my concerns, but we must move forward.

ASSEMBLYWOMAN CONSIDINE:
For me, this is an opportunity that has not presented itself before. I believe we need to jump on this movement to provide relief to Nevadans. We need to run. If the drugs on these lists are nonbiologic, they must be on the market for at

least seven years with no competition. If they are biologic, it will be more like 12 or 13 years.

Regarding profits and competition, our Country is based on competition. Businesses do better when there is competition. Prices lower when there is competition. When volume goes up, prices come down.

These drugs currently do not have competition. However, if demand increases from Nevadans who access these previously unattainable prescription drugs, insurance companies could potentially transfer them to the three-tier system mentioned by my copresenter.

For example, you may need a drug, but it is too expensive even though it might be the best option for you. Instead, you have to start with a Tier 1 drug, a lower-cost drug that might not work. You are required to use this lower-cost drug. If it does not work, then you go to Tier 2 drug. If that does not work, then you go to Tier 3. All of these have financial costs, mental costs and physical costs.

If these MFPs are low enough that insurance companies utilize them by lowering the tiers, that saves multiple levels of additional costs while at the same time increasing the volume of sales. That goes back to Senator Daly's point about increasing profits.

SENATOR PAZINA:
I have a question about section 1, subparagraph 3, about maintaining a registered agent and base of operations in the State. It harkens back to A.B. 107, which we passed out of this Committee last week.

ASSEMBLY BILL 107: Revises provisions governing certain pharmacies located outside this State. (BDR 54-109)

Does A.B. 107 conflict with A.B. 250? Section 1, subsection 3 of A.B. 250 says:

> Except as otherwise provided in subsection 8, a person or entity that sells, offers for sale, distributes or delivers any referenced drug to a person or entity in this State or seeks reimbursement for a referenced drug which is delivered, dispensed or administered to a

> person in this State shall maintain in this State a registered agent and an office or base of operations.

With A.B. 107, we were considering providers outside of the State being able to help those inside the State. I did not know if there is a conflict.

MS. MARSHALL:
We are fine with removing that. Since my time as State Treasurer and Lieutenant Governor, it was stressed that I should always include that language in everything I did. In fact, that is just a habit from my past. If a bill no longer requires that, you have some other means to have that oversight.

ASSEMBLYWOMAN CONSIDINE:
This was not brought up in the Assembly. I was unaware of A.B. 107, but I will review that today and get back to the Committee if the Chair likes.

CHAIR SPEARMAN:
Thank you.

SENATOR STONE:
Thank you, Lieutenant Governor, for sharing your story, and Godspeed that you should stay in good health.

Assemblywoman Considine, I appreciate your efforts to contain drug costs, which can be expensive. We have spoken on the phone about this, and I shared some concerns I have with the bill.

The first thing I am going to talk about is federal patent laws. I know some of this stuff. As many of you know, I recently retired, but I was a practicing pharmacist for 42 years. I owned six pharmacies and dealt with buying prescription drugs directly from manufacturers and wholesalers.

When a drug company files a new drug application, the clock starts ticking for the patent. Today, the patent is 20 years from the date of application. Sometimes it takes five, seven or eight years, maybe longer than that, to get a drug on the market. The difference the drug company has to make up must cover that time frame, too.

I appreciate what you say about competition. Without these patent laws, the drug development companies would never get a return on investment or take

the chance of spending billions of dollars to develop new drugs for things like cancer, autism and hepatitis.

These are federal patent laws. A supremacy clause in the Constitution is at stake here. What you are trying to do here today has actually been tested.

The District of Columbia wanted to have price controls. Its law went all the way to a federal court. It was overturned. The court said it is the purview of Congress to determine whether there are any drug discounts or negotiability, in that regard, with drug companies. Thus, the first concern is the legality of what you are trying to do.

Assuming that the bill gets passed and is enrolled, there are more concerns. Many people have insurance coverage. What is the guarantee the insurance company will pass that lower price on to the patient in the way of lower cost or lower copays?

Then if the law is passed, how will that affect me as a pharmacist? I do not negotiate with my wholesaler except for the discount I get or the cost plus I get with the wholesaler.

A couple of companies may still allow a pharmacist to buy direct from a wholesaler. For the pharmacy, the advantage of buying from a wholesaler is that you might get a 2 percent discount if you pay your bill on time.

Your bill targets pharmacists. If they are unable to buy a drug at the price you are advocating and they do not sell the drug at that predetermined discount, then the pharmacist can be held liable through a private right of action for deceptive trade practices. I will tell you that most pharmacists do not have deep pockets where they can sustain a lawsuit like that.

If this bill becomes law, pharmacists will not be able to buy at this discount because the drug companies will not lower the price. Pharmacies will just not stock the drug. They will tell patients, "We do not stock that drug."

There is no law that mandates that pharmacists must dispense any prescription. We can refuse service for any reason we want. For instance, if somebody comes in with multiple prescriptions for Vicodin, we can say, "Sorry, we are not going to fill this; we think your frequency is too much." Or if somebody comes in and there is a drug interaction between their prescriptions but the patient still

wants it, we can say, "We are not going to dispense this drug." Pharmacists do not even have to give a reason. They can say, "Sorry, we cannot fill your prescription at this time."

Here are my questions: How are you going to overcome the supremacy clause of the federal Constitution? How are you going to guarantee that the insurance companies pass on the savings to the patients? How are you going to deal with pharmacies who will not stock the drug because they will not get the discount? Why are you targeting the pharmacist who has no control over what a pharmacy manufacturer discounts or sells a drug for? Why was the private right of action not against the drug manufacturers?

MS. MARSHALL:
I appreciate these questions, especially since you are a pharmacist. I need to start with a caveat: I am not a patent lawyer; I am an antitrust lawyer. Antitrust law often intersects with patent law these days, especially when it comes to lots of things made in China.

With respect to the patent laws, the IRA dealt with that. In response to your questions, I will parse between trying to relitigate the IRA—which is not what this bill does, but which some of this conversation is about—and then dealing with A.B. 250.

The IRA basically said for those 10 drugs it chooses, the patent, the exclusivity, will be anywhere from 7 to 13 years. Congress has the right to decide that.

During the development of the IRA, Congress became aware that many of these manufacturers were taking a drug that had been on the market 17 years, slightly altering it and putting it back on the market. It was a "Cornflakes—new and improved!" ploy, and it extended the patent for another 17 years.

The federal government is putting a stop to that silliness and exclusivity. That is something the drug manufacturers should never have had. After all the negotiations, it was decided that certain drugs had 7 years exclusivity, another drug had 9 years, a different drug 13 years. That aspect of patent law has been decided at the federal level, and that is not the concern of A.B. 250.

The IRA changes the landscape. Nevada is not doing anything but simply adopting, by reference, federal law for everyone else. We are not passing requirements on anybody except to say that when you, a patient, go to the

pharmacy, you will pay no more than the Medicare-negotiated MFP. This gets to your point about the delta to the patient.

The insurance company does not have an option. The IRA dealt with this. One reason we have two years to work through this is the IRA says the pharmaceutical manufacturer needs to determine how it is going to get that medication on pharmacy shelves at the Medicare-negotiated price. Not the insurance company, not the pharmacy benefits manager, not the pharmacy: you, the drug manufacturer, are obligated to get that medication out there.

In regard to pharmacists and whether they will have that medication, they will certainly have the medication available for Medicare patients.

Currently, in discussions in Washington, D.C., pharmaceutical manufacturers are saying, "If this is the case, we are only going to sell to CVS and not to individual pharmacists at the Medicare-negotiated prices." They are making all kinds of grandiose accusations.

Now we come to the fact that I am an antitrust lawyer. When we talk about markets, we assume an open and spontaneous competition. We assume prices are set by supply and demand with each seller acting in a nondiscriminatory way, not saying, for example, "I am only going to sell to CVS."

That is what we assume when we talk about markets. But here you have Big Pharma threatening not to sell to anyone under the age of 65. We are talking about the same medicine, at the same price, for the same condition. That is a monopolistic action designed to manage prices without competition or market forces. That is monopoly behavior.

Here in Nevada, we are proud of our capitalist economies, open markets, competition and choice. As an antitrust lawyer, I can tell you that when the antitrust lawyers say you should have the liberty to buy and sell, they do not mean the liberty to maintain price controls by holding consumers hostage until they agree to pay monopoly prices. They do not mean holding pharmacies hostage until they agree to pay monopoly prices. I do not think our Legislators will take kindly to that threat. That is not who we are.

It is not our character as Nevadans to play that game. I also think Big Pharma's lawyers have yet to engage in reviewing those kinds of threats from a legal viewpoint. They have not considered their exposure for engaging in

monopolistic behavior that causes a loss of life. I do not think they have thought about the risk associated with that actual activity.

SENATOR STONE:
In the early discussions of the IRA, private insurance companies were included and then removed. I still do not understand how Nevada has the power to force a drug company to sell a prescription drug at a price that was negotiated with Medicare in response to the IRA.

By the way, we do not even know the details of what that type of negotiation will be. We have no idea because it has not happened yet. We probably will not know for a couple of years. I guess we will agree to disagree. I share the same premise that you do. I would love to find a way for pharmaceuticals to be less expensive, especially the more costly drugs.

When you see the advertisements on television for many of the Big Pharma drugs, a lot of their direct marketing puts a caveat in the commercials: if you cannot afford this drug, there may be a special program to reduce costs. Many of the pharmaceutical companies are philanthropic and do not want to see people go without medications. They try to provide discounts for those who cannot afford the prescriptions.

Unfortunately, we often demonize drug companies because they charge a lot of money. In other countries, there are federal price controls. If you do not comply with those price controls, you cannot sell that drug in the country.

Hepatitis C provides an example of why we have such a great pharmaceutical industry. Hepatitis C patients used to be told to get in line for a liver transplant, which is about $1 million. Then they must be on antirejection drugs the rest of their lives, which will cost another $1 million.

Then a company came out with a drug called Sovaldi, which is a cure for hepatitis C, if you can imagine that. It was not an intravenous drug; it was oral therapy for six weeks. When people saw the cost of it, about $80,000, they almost fell on the floor and said, "My gosh, how can you charge that kind of money?" But compared to patients saving $2 million and possibly their lives, there is no comparison. What is a life worth? Then as we saw more competition in that pharmacological class, Sovaldi adjusted its prices. With competition, it is lowering its price and dealing more proactively with PBMs.

I worry that if we do not invest in these pharmaceutical companies, we will not see timely cures for diseases like cancer. My mom passed away from breast cancer at the age of 57. If she were diagnosed today, she probably would survive. I have a grandchild with a severe case of autism. I hope we find some pharmaceuticals for autism.

We must consider how many drugs come on the market and how many do not come on the market after billions of dollars are spent on R&D. Sometimes there are side effects; maybe the drugs kill people in addition to healing them.

These are some of the struggles I have in terms of wanting to provide affordability to patients who cannot afford medications. At the same time, I want to make sure that R&D continues so we can have cures for the serious diseases.

MS. MARSHALL:
Let me parse through this. Some of this is really about the IRA. Let me try to explain it.

Senator Stone's major question about A.B. 250 is where does the State get the right? We, the State of Nevada, are not setting price controls. We are saying that the patient will pay no more than the negotiated price. The patient can pay less. We are not telling the manufacturer what to charge. The patient will pay no more than the negotiated price.

It is interesting to me that when they set a cap on insulin in the IRA, Merck came out quickly and started offering insulin at a lower price. I mention that as an aside of what happens when you make a market actually competitive. Here in Nevada, we have the right to say that the person will pay no more than this amount. That is different than saying that to the pharmaceutical company.

I do want to strongly correct the notion of whether pharmaceutical companies are demons. As an antitrust lawyer, I can tell you that they are companies. They are bound to maximize their profits. They are bound to the best they can with the products they have for the constituents they serve and their stockholders. That has nothing to do with being demons. I am here, and many of us are here, because of the medications they provide. I will get to R&D in a moment.

I want to talk a bit about negotiation. We do know some of the parameters of the negotiation regarding the top 50 drugs. They must have been on the market

for a certain amount of time. There can be no competition coming up in the next two years. If pharmaceutical manufacturers can show a company is about to enter the market within two years, that drug will not be put on the list.

The drug must be exclusive, no competition. It must have a high cost. Medicare must spend a lot of money on the drug. Those things have to happen. They are allowing in those negotiations for a reasonable profit. That is part of the negotiation.

The drug prices will be reduced anywhere from 20 percent to 60 percent, depending on what the profit margins have been in the past. We are not doing that negotiation, but I can assure you it is happening, and all of Big Pharma is at the table.

Let us talk about R&D. The Congressional Budget Office (CBO) did an analysis to ask what happens to R&D if we pass this IRA? Let me correct a few misconceptions. First, not all R&D is conducted by public universities. Most foundational research is conducted by public universities, but the private sector produces the therapies. So let us dispel that myth.

As to the question of pharmaceutical companies spending on R&D as compared to marketing, pharmaceutical companies spend two to three times more on marketing than on R&D.

As for R&D itself, the CBO said that over the course of a decade, there would be two fewer therapies as a result of these actions. That CBO analysis was issued when the IRA under development still included commercial insurers. So, Senator Stone, there is your answer.

ASSEMBLYWOMAN CONSIDINE:
I was talking to folks in Las Vegas over the weekend, and this bill came up. That reminds me of Senator Stone's point about the worth of a life.

I do not know if you are talking about people who are working class and struggling to pay their bills, or if you are talking about a person who has fantastic insurance and could potentially afford an $80,000 health bill. The woman I was talking with is a nurse. She went to a chain pharmacy to get a prescription filled for her daughter. The pharmacist told her the cost after insurance was $200.

She was knowledgeable enough to say, no, forget it, and she canceled that prescription. She told the pharmacist she would go elsewhere. The pharmacist told her to go ahead, but her insurance would not cover it at a different pharmacy.

She went to another pharmacy based out of a supermarket. She put in the request, and the insurance did not cover it. But then she got a phone call two hours later from the pharmacy saying apologizing that it could not fill the prescription, but they found her a manufacturer's coupon, and now her cost would be just $24.

That is just an example of other options. In terms of the marketing and commercials, it does say if you cannot afford the prescriptions, call X. However, you cannot just call and say I need this drug. You must go to a doctor who prescribes the drug, then you have to see the commercial, remember the number to call and then call to request the discount.

For most people, including my friend who told me the story, those commercials are not useful unless somebody knows about it. You have to be in the right place at the right time to even know the discount is available. Then you have to contact them and go through the whole process—or, as I just shared, go to a different pharmacy and get the drug for much less, even though your insurance was with a different pharmacy. I bring this up to highlight that our healthcare system, although one of the best in the world, has flaws.

This bill could provide direct relief to people so they do not need to watch the commercial and get the coupon. They do not need to go from one pharmacy to another for an affordably priced prescription that will not cost them their rent payment, their car payment or their house.

This bill skips over everything. It says, if your doctor thinks you need this prescription drug for your life-altering health situation, this is the maximum amount you will pay wherever you go in Nevada.

SENATOR BUCK:
Can you clarify the private right of action?

MS. MARSHALL:
Our consumer protection laws say that if someone commits a fraud or violates those consumer protection laws, an attorney can bring a lawsuit on behalf of

that person, the person can go and represent themselves, or the State's Office of the Attorney General can bring a lawsuit.

This basically incorporates that into this bill. It says if you, the patient, cannot purchase the prescription at the Medicare-negotiated price, there is a right of action. It also applies if the pharmacy cannot purchase the prescription at the Medicare-negotiated price, or if the insurance plan cannot purchase the prescription at the Medicare-negotiated price.

Remember, under the IRA, it is a requirement that the manufacturer make that product available to the patient.

Part of the right of action is the $2,000 per transaction. Let us say that you need a particular medication once a month. Each time you go to get it and cannot, that is a violation. If the pharmacist wanted to order 50 units, each transaction would be a private right of action.

SENATOR BUCK:
If I am a hospital, a small pharmacist or even a large retail chain, am I subject to private right of action if this bill passes?

MS. MARSHALL:
If you are doing what Senator Stone suggested might happen, which is keeping the delta for yourself and not providing the Medicare-negotiated price, then yes.

SENATOR BUCK:
You focused a lot on manufacturers. Can they also get sued?

MS. MARSHALL:
Yes.

SENATOR BUCK:
It is a whole continuum. Is there a requirement that the insurance company must pass on the savings?

MS. MARSHALL:
There is no requirement that you sell at a certain price. There is the requirement that the person only pay the negotiated price. However, if you require the person to pay more than the negotiated price, then you are in violation of the consumer protection laws.

SENATOR BUCK:
If the manufacturer sells it for a lot, then you stop anybody from covering it. On another line, what is the exact timeline for the federal government to identify the specific drugs?

MS. MARSHALL:
At this point, there is a list of 50 drugs, and they are currently determining the first 10 to be included on that list. The first ten will be identified by September 2023, and more drugs will be added to the negotiated price list each year thereafter.

CHAIR SPEARMAN:
It seems like there is a hang-up about what negotiated price looks like. Can you explain the process for negotiating the correct price?

MS. MARSHALL:
This September, the first ten drugs will be identified. In September 2024, the price for each of those drugs will be published. All of us will know the negotiated prices; it will be public. Then in September 2025, they can start to roll out the new prices. By January 2026, the drugs will be available at those new prices.

What is likely to happen is a bit more detailed. Many of those drugs are currently not covered by insurance. They are not in the formulary with the insurance companies. That must be negotiated with the PBMs and the pharmaceutical manufacturers.

When you start to lower the cost of a particular prescription drug, the pharmaceutical manufacturers will want to increase volume. That in turn means they would like it prescribed earlier in the treatment. That begins the negotiation process with the insurance companies and the PBMs. How often is the drug taken? How much? What are we talking about?

Those negotiations will happen, and then we will see our prices at the individual level. But for those 10 drugs in Nevada, you can be 65 years old or 45 years old. If you have asthma and that drug is covered, you are going to pay the negotiated Medicare price.

ANNETTE MAGNUS (Battle Born Progress):
We are in strong support of A.B. 250. Prescription drugs are often necessary to treat and manage various medical conditions. In many cases, they can be lifesaving. However, the high cost of prescription drugs can create significant financial barriers for many people and prevent them from accessing necessary care.

With A.B. 250, which we are calling the Affordable Medicine Act, Nevadans will pay the negotiated price and benefit from the regulations on how companies change and control pricing.

You have heard and will continue to hear this Session that Nevadans are suffering and need economic relief. This bill brings much needed relief by stabilizing drug prices. We can help people suffering from high drug costs. No one should have to choose between taking medication and living. We must do better in this State. As somebody with asthma, I feel this bill is critical. We urge your support of A.B. 250.

CHRIS DALY (Nevada State Education Association):
The Nevada State Education Association (NSEA) has been the voice of Nevada educators for over 120 years. We are also in support of A.B. 250 to address the skyrocketing costs of prescription drugs.

This Session, NSEA has spent a good deal of time talking about the stagnant and relatively low pay of educators. The teacher wage gap is at 80 cents on the dollar, and the workers who make our schools run earn as little as $11 an hour.

The other side of this coin is household costs, which have skyrocketed in recent years. For many educators, and especially our retired educators, their biggest pocketbook issue has been healthcare costs, driven in part by the increasing cost of prescription medications.

This bill will help rein in these costs, providing relief to thousands of Nevada educators and retirees. It is smart public policy that is fair and critical to the health and well-being of everyday Nevadans. We ask for your support.

TESS OPFERMAN (Nevada Women's Lobby):
One of the four main priorities of the Nevada Women's Lobby is access to health care. A core piece of this is looking at prescription drug prices and working to ensure they are affordable for all Nevadans. We are especially

supportive because one of the drugs being looked at is a treatment of HER2 breast cancer, which affects women of all ages, not just those 65 or older.

All women should be able to access these lifesaving and critically important medications. Drugs that treat asthma, diabetes and blood clots are all being reviewed. These conditions affect populations of all ages, not just those aged 65 and older. Lieutenant Governor Marshall talked about the choices families face when dealing with health conditions and expensive medications.

Families are choosing between critical drugs, food on the table and a roof over their heads. We are in full support of A.B. 250 and all measures that help limit the high cost of prescription drugs.

The IRA took a huge step by passing legislation that would create a maximum price index for certain drugs. But Nevada needs to take the next step by ensuring all ages can benefit from these maximum prices. Please pass A.B. 250.

KENT ERVIN (Nevada Faculty Alliance):
We support A.B. 250. We have been following the Public Employees' Benefits Program for many years. Drug costs have been a major driver of costs for participants and the State over the years. The increasing costs of health care impact our members and State employees with chronic conditions who need these drugs to stay productive in the workplace.

Over the years, we have been frustrated by the lack of transparency in the pricing models of the drugs, all the intermediaries and the various ways companies use rebates to influence the marketplace. This kind of bill to help control costs is very important.

MARIA MOORE (State Director, AARP Nevada):
Today I speak on behalf of Nevada's 347,000-plus AARP members in support of A.B. 250.

The AARP in Nevada believes that we must engage individuals and communities to support healthy living. Further, it is vital to the well-being of Americans that individuals, government and the private sector should work together to promote improvements in health.

A principle of this philosophy is that as a society, we must ensure adequacy and affordability. Costs such as premiums, deductibles and other out-of-pocket

expenses should not be burdensome to consumers or limit access to coverage of necessary services. Sufficient financial assistance should be available to low-income consumers to ensure affordability for all. This bill is step in the right direction.

ARIEL GUEVARA:
I am a regional organizing director with For Our Future Nevada, but today I am providing testimony (Exhibit F) on behalf of Elizabeth Yanez, a registered nurse.

CYRUS HOJJATY:
When it comes to the prescription drug industry, the market, left to its own devices, is not efficient in determining the best prices for consumers. Peoples' lives are at stake.

I am surprised many people voted no on this bill in the Assembly. It does not make sense to me. I am glad we are fighting against Big Pharma, but I wish more had been done during the events of the last three years.

This bill will help our economy. People are paying too much for these prescription drugs. Just imagine how much economic activity is lost. With all the savings we could have, people could pay for housing and many other expenses. That would jump-start the economy. Hopefully, this bill will pass. Something must be done; we must raise the alarm.

ERIC JENG (Nevada Asian American and Pacific Islander Chamber of Commerce):
I am the acting executive director of Asian American and Pacific Islander (AAPI) Chamber of Commerce, Nevada. This State is home to more than 282,000 Asian Pacific Islander Americans, about 12.5 percent of our total population. As the fastest-growing community in Nevada, we are aware how our advocacy needs to be rooted from real Nevada families.

From data research, canvassing and talking to our community members as we go door-to-door, we know that health care, especially affordable prescription drugs, has always been a top issue.

Nationally, Filipino Americans spend the most on prescription drugs of any Asian ethnic subgroup. Filipino Americans make up 45 percent of our AAPI community here in Nevada. Our community also has higher rates of diabetes.

This bill would help ensure that all residents have access to affordable prescription drugs. It would reduce healthcare costs overall and stimulate the State's economy. It is time for Nevada to take action to address the high cost of prescription drugs and leverage federal action and negotiation to ensure that all State residents can enjoy the savings. We urge your support for A.B. 250.

BRIANA ESCAMILLA (Planned Parenthood Votes Nevada):
I am calling on behalf of Planned Parenthood Votes Nevada in support of A.B. 250. All Nevadans, regardless of income level, deserve access to the medications they need to live healthy lives. Costs should never be a prohibitive factor in receiving lifesaving and medically necessary care. We urge your support.

UNIDENTIFIED TESTIFIER:
I am a proud resident of Senate District 11. I am a retired special education teacher and a member of the Nevada State Education Association—Retired.

I have COPD and a heart condition. My wife has asthma and is currently being treated for cancer. Last year, we spent well over $8,000 for lifesaving drugs. Much of that was put on credit cards that were rapidly overwhelmed.

Luckily, help is on the way for us because the IRA allows Medicare to negotiate prices for prescriptions. However, many people we know will not be eligible for Medicare for several years.

All Nevadans should be covered by the benefits of those negotiated prices. Why should Big Pharma be allowed to make billions of dollars on the backs of those who can least afford the cost of the drugs? All the while, they continue to receive our money for R&D through government grants.

Why do we have to watch commercials for drugs? Let my doctors decide what is best for me, not accountants and advertisers. This is the time to help all Nevadans. Please support A.B. 250.

MARLENE LOCKARD (Service Employees International Union Local 1107):
High drug costs can be a major burden for our members, especially those with chronic conditions who rely on medication to manage their health. Without affordable drugs, people may be forced to forego necessary treatments or cut back on their medication, which can lead to serious health complications.

This bill is important so all can benefit from the negotiated rates Medicare will make with drug companies. We support A.B. 250 and hope you will too.

MATTHEW WILKIE:
I have been a pharmacy professional for 13 years. I am here to express my support for A.B. 250. As a healthcare provider, I see firsthand the struggles that my patients go through when they cannot afford their prescription medications.

They are forced to make impossible decisions like picking and choosing between filling that prescription and buying the groceries in their carts. That is why these drug caps and the fair market prices are so important, especially for the people of Nevada.

The cost of health care is rising everywhere, but it is particularly acute in our State. Many of our residents are low income and simply cannot afford the rising costs of prescription medications.

This bill will prevent unnecessary hospitalizations for people who skipped their medications. It will ultimately improve the quality of life of all Nevadans. I urge you to support A.B. 250. Our residents deserve access to affordable health care, and this is one small step we can take to help make this happen.

CHAIR SPEARMAN:
We have received many letters in opposition (Exhibit G) to A.B. 250.

DANNY THOMPSON (Pharmaceutical Industry Labor-Management Association):
I am here today representing the Pharmaceutical Industry Labor-Management Association, a trade organization group comprised of international unions and the pharmaceutical industry.

Our president this year is from the International Sheet Metal Workers Union. We have trustees representing the International Brotherhood of Electrical Workers, Operating Engineers and Ironworkers, to name a few.

We are against this bill. To begin with, we do not even know what drugs will be on the list based on the federal government's criteria. Passing this bill now is premature.

The State Legislature here meets once every two years, and there will be another session before all of this happens. It is prudent to wait and review the ramifications of these changes first because it is complicated.

If you get it wrong, who knows? I do not know what is going to happen, but I do know that it does not make sense to pass this bill before you know which drugs are on the list and other ramifications.

We urge you to wait until the next Legislative Session. I do not know of any other state in the Nation that is considering a bill like this. It is prudent to wait. We are in opposition to this bill.

DHARIA MCGREW, PH.D. (Pharmaceutical Research and Manufacturers of America):
I am the director of state policy for Pharmaceutical Research and Manufacturers of America. I am here today in respectful opposition to A.B. 250 for many reasons. We have provided a letter in opposition (Exhibit H).

Is the health care system completely off kilter? Yes, we agree. But this bill is oversimplified. It is not the solution you think it is.

The drafter of the bill misunderstands the pharmaceutical supply chain. It does not give Medicare copays to everyone else. The MFP that will be determined by the federal government for Medicare is a price for a government payor or a health plan. It is not the price that patients pay. So it still may be well over what is affordable for the average citizen.

It contains no mandate for health plans to lower your co-pay. Nothing requires them to take the savings they get and lower premiums. We all have a part to play, but this proposal lets insurance plans and middlemen completely off the hook for their role in the cost of medicine.

Solutions that truly help constituents must look across the supply chain and bring all entities to the table or to task, if that is what you wish.

Additionally, this bill is premature and hastily drafted without complete information. It skips past transparency and data and analysis of cost drivers in the State. The federal law does not go into effect until 2026 because they need all that time, possibly more, to figure out how it will be implemented. The

process just got underway and there are complex operational and legal issues to be sorted out. And that is just for Medicare.

This bill simply does not codify that for the rest of the State. It broadly expands the federal concept in completely uncharted ways. The commercial market is different from the government-funded Medicare market. There are no mechanisms in this bill for regulating and making any State-level decisions.

There is no need for the State to try to fly a plane while the feds are still building it. This concept needs more work, and we ask you not to pass this bill this year.

JIMMY LAU (Biotechnology Innovation Organization):
I am representing the Biotechnology Innovation Organization, a trade organization with more than 1,000 biotechnology members across the U.S., in opposition to A.B. 250. We have written a letter of opposition (Exhibit I).

This bill does not contemplate the realities of the prescription drug supply chain and could negatively impact access to prescription medications. Pharmacies, hospitals and doctors in Nevada that provide medicines to patients must first purchase those medicines, often through national distributors or across State purchasing groups.

These purchases are not controlled by A.B. 250. The providers will likely have to acquire these medicines at a cost higher than the MFP. This places providers in an untenable situation of losing money to provide the medicines the patients need or not stocking certain medicines.

Additionally, this bill misapplies the IRA's maximum fair price as a cap on consumer spending. The MFP is intended to be the price a Medicare Part D plan pays for a drug, not what the Medicare recipient must pay at the pharmacy counter.

Proponents discuss the point-of-sale transaction where the MFP would apply, but the pharmacy does not bill the patient for the cost of the drug. They bill the patient's health plan, and it determines what the patient pays. The provisions of the IRA intended to benefit patients and lower their out-of-pocket drug costs are found in the law's caps on out-of-pocket spending, which are different from the MFP and are not included in A.B. 250.

Finally, we oppose price controls because they result in loss of investment for future innovations. That means fewer new medicines will be approved. Numerous estimates for the IRA forecast a reduction in investment for new therapies.

But more importantly, the CBO forecasts a reduction in the number of drugs introduced into the U.S. market, meaning less opportunity to improve the lives of Nevadans.

We appreciate the intent to lower prescription drug costs, but we do not believe this policy is the right way to accomplish this goal. We ask the Committee to oppose this bill.

AMY SHOGREN (Nevada Hospital Association):
The Nevada Hospital Association is in opposition to this bill. There are many unknowns at the federal level. This bill would restrict the pricing of pharmaceuticals sold here in Nevada and may actually decrease access to patients and transparency in the process. We ask you to oppose the bill.

ADAM PORATH, PHARMD (Nevada Society of Health System Pharmacists):
Our organization is opposed to this bill. We signed a letter in opposition (Exhibit J), along with other groups.

We are particularly concerned for hospital and health system providers that are our safety net hospitals. These are our disproportionate share hospitals and critical access hospitals that utilize the 340B Drug Pricing Program.

That program and the funding those facilities receive is completely funded on the delta for commercially insured patients. If you remove that, you are removing the funds supporting indigent care for those critical access hospitals and disproportionate share hospitals.

LIZ MACMENAMIN (Retail Association of Nevada):
I am representing many of the community pharmacies in the State that are concerned. We also signed the letter of opposition Exhibit J.

With few exceptions, the providers—the pharmacy, hospital or clinic that dispenses or administers drugs to patients—must first purchase the physical product and then receive reimbursement to cover the cost of the product.

The complex system in which drugs are purchased and then distributed—from a manufacturer to a wholesaler, to a healthcare provider and finally to the patient—involves numerous transactions between each entity, and with insurance companies, PBMs and government payors.

At each step along the way, these transactions are subject to private negotiations and often involve complicated discount and rebate arrangements.

This bill puts our State providers and other healthcare entities at risk. Even if Nevada establishes a cap on the price for prescription drugs based on the MFP, the price at which these drugs are bought and sold nationally will remain unchanged to the pharmacy, to the end provider and to the patient. Many Nevada providers purchase drugs through out-of-state transactions that would not be subject to the limitations of A.B. 250.

In-state distributors and providers will purchase drugs at a national price and then be subject to the in-State cap. Providers then have to choose whether to purchase drugs for more than they can be reimbursed or stop purchasing some drugs altogether. This, in turn, could drive the patients to out-of-state retail and mail-order pharmacies, further deepening the impact on our healthcare environment here in Nevada.

This bill also puts patient access at risk. Healthcare providers often lose money on claims for prescription drugs. However, if pharmacies, clinics and hospitals lose money every time they dispense or administer certain prescription drugs, they may find it infeasible to stock certain drugs.

But my biggest concern is for patients in Nevada. If those drugs are not available here, where will they get them? We urge you to review this. Maybe next Session we could look at prescription benefit managers. They have a real impact on the cost of drugs to Nevadans.

TOM MCCOY (Nevada Chronic Care Collaborative):
Most Nevadans would be okay with a "try it before you buy it" program but not a "buy it before you could even try it" program. But that is what A.B. 250 wants the State to do. It is a statutory tie to a federal program not fully implemented, pertaining to drugs not identified, for fixed prices not negotiated. This bill is just too premature and should be opposed in this Legislative Session.

PAUL MORADKHAN (Vegas Chamber):
We appreciate the perspective shared by the proponents of the bill and what they are trying to achieve. The Vegas Chamber has over 70 sectors within our membership, including health care and several subsets within the healthcare industry.

Our members have reached out to the Chamber about their concerns with the bill and negotiated pricing. This bill could potentially impact drug deliveries and cause shortages in our State. It could lower R&D spending, which impacts next generation development of prescription drugs. Fewer new prescription drugs will reach the market. This will cause longer wait times to access prescription drugs.

There is also the concern about getting ahead of the federal government. The Vegas Chamber always has concerns about any potential private right of action.

EMILY OSTERBERG (Henderson Chamber of Commerce):
The Henderson Chamber of Commerce and its 1,800 members, most of which are small businesses, oppose A.B. 250.

Regulating pharmaceutical companies to base pricing on Medicare costs will potentially stifle innovation, negatively affecting the business community in Nevada. In addition, this bill has wide-ranging impacts for our healthcare members including hospitals and pharmacists who would be subject to a private right of action in the event they violate a provision of the law.

These measures only add to the cost of operations of these types of businesses. These costs are ultimately passed on to the consumers and patients that this bill is meant to assist.

KAYLYNN BOWMAN, PHARMD (Nevada Pharmacy Alliance):
I am the current president of the Nevada Pharmacy Alliance, and we are in opposition to the bill as currently written. We submitted a letter in opposition (Exhibit K).

I understand Nevada patients need access to affordable medication. However, pharmacies do not set drug prices or control what they are reimbursed when medications bill through insurance. Drug manufacturers and PBMs control this part of the drug supply chain.

Recently, a situation occurred where pharmacies purchased items and were not reimbursed. The dispensing fees were not included; the rates were lower than the pharmacist could obtain the medication. Obviously, losing money on transactions is not a sustainable business model. The pharmacist must refuse to provide medication to the patient. This leads to frustration for both patients and pharmacists. It does not allow for our small independent pharmacies to compete with the larger pharmacy chains.

This bill requires manufacturers to not charge a price higher than the MFP calculated. Our concern is this does not consider what price the wholesaler sells medications to a pharmacy, or what price a PBM will pay to reimburse the pharmacy for their services. In the past, pharmacies have been the one harmed in this type of situation because they did not have a say in the process. This has caused pharmacy closures.

Another part of the bill that concerns us is that any person aggrieved by a violation of this rule may bring an action for consumer fraud against that entity. The pharmacists and pharmacy do not control the price the manufacturer sets, the price the wholesaler charges or the PBM's rate of reimbursement to the pharmacy.

The only thing the pharmacists and pharmacy can control is whether it makes sense to dispense medication to the patient. It is an unfair dilemma for pharmacists who want to help the patients and community by ensuring access to medications. There is no consideration of how this may hurt the business.

There should be amendments to this bill that would make sure the rates for dispensing a product are not lower than the prescription price. It should also exclude pharmacists and pharmacies from being included in anything to do with consumer fraud in regard to pricing.

WISELET ROUZARD (Americans for Prosperity Nevada):
We strongly oppose A.B. 250, which is a pharmaceutical drug price control bill. This bill basically does what everyone said. It is making it a crime under Nevada consumer fraud law to sell a prescription drug in Nevada at a price above Medicare's MFP.

This harms the patients that Medicare and the bill's sponsors want to help. These price controls often lead to significant shortages. It will stifle innovation.

This is not a monopoly in the sense of what the bill presenter said. The monopoly is in the regulations that both the State and federal government have implemented to ensure these pharmaceutical companies or manufacturers are protected from free and fair competition entering the market to provide quality pricing.

This bill will restrict access and options. It will proliferate medical tourism. It will cause Nevadans to go to other states or countries to access drugs that this law would restrict these manufacturing pharmaceuticals from providing.

Using taxpayer's dollars and the lethal force of the law is not a capitalist society, but more of a communist socialist society that results in a degradation of life, liberty and everyone's pursuit of happiness.

The bill presenters say this is not a price control bill, but that is misleading. It actually is. Whenever you use the law and taxpayer funds to tell a business what they must do and then use the law to enforce it, that is price control. This leads again to loss of investment.

I urge every member to vote no. If we want to have the best health care in the world, we urge you to deregulate this industry. Allow more competition to ensure prices are diminished and quality, more access and alternatives are provided to Nevadans.

LEAH LINDAHL (Healthcare Distribution Alliance):
The Healthcare Distribution Alliance (HDA) is in respectful opposition to A.B. 250. Our members serve the critical logistics providers in the Nation's pharmaceutical supply chain. Our wholesale members of the industry connect over 1,500 manufacturers to roughly 300,000 points of care across the U.S., including 400 in Nevada.

In their role as wholesalers, HDA members do not manufacturer, market, prescribe or dispense medicine. They do not set the list price of prescription drugs or set third-party payor reimbursement rates or coverage rates for patients in the State.

Furthermore, our members do not have insight into the pricing of dispensable units or the price that consumers pay when they get to the pharmacy counter. Wholesalers also operate under a fee-for-service contract with the Nation's

manufacturers. These contracts are not State-specific. They are done on a national scope.

Applying a federal pricing policy to the State-level purchasers would conflict with how the supply chain currently operates. Establishing a cap on the purchase price and reimbursement of a product would leave little ability for a pharmacy, clinic or other point of care to recoup costs for administering or dispensing products. It will just cause a lot of havoc in the industry.

This is also based on the IRA, which has not been implemented at the federal level. Taking a federal stance into a State could cause undue burden on the State's patients. We would appreciate a no vote on this legislation.

JARRETT CLARK:
I support A.B. 250. I am the communications director at For Our Future Nevada, and I am testifying here today on my own behalf. I strongly urge this Committee to approve A.B. 250. Simply put, this legislation will benefit countless Nevadans who rely on insulin and other medications for their well-being.

Thirteen years ago, I was diagnosed with a rare genetic blood disorder that puts me at high risk of developing a life-threatening blood clot. Managing this condition requires regular doctor visits and a name-brand prescription drug, Xarelto, which has steadily increased in price because there is no generic version available. The out-of-pocket cost of this medication is more than $700 a month for people without insurance. This is absurd, since it literally saves lives by preventing strokes, embolisms and heart attacks.

Fortunately, I have been able to maintain private health insurance to shoulder most of that cost. But many Nevadans out there are not so lucky.

Under the IRA, Medicare is now empowered to negotiate drug prices for seniors. It is expected that the price of the medication I take will soon be negotiated to make it affordable. This bill will extend the negotiated prices of specific prescription drugs to all Nevadans who need them.

In my work, I regularly speak with Nevadans of all ages who struggle with chronic health conditions like diabetes, respiratory illnesses or blood disorders like mine. Many of them must choose between their lifesaving medications, the rent or other bills. People have died rationing their medications due to exorbitant

costs. This bill is a strong step toward reining in out-of-control drug prices. Lives will be saved because of it.

ASSEMBLYWOMAN CONSIDINE:
Everything you have heard this morning in opposition is exactly what I have heard. It will cause the end of private R&D. It will cause cost-shifting. It is someone else's fault—the PBM, the insurance company, the supply chain. The system needs to be fixed first. We cannot do it now. We can do it two years from now. We will lose profits. I have heard all of those reasons.

One of the reasons why A.B. 250 is the most elegant solution is because these two monster industries are fighting each other, like Godzilla verses King Kong. They are fighting each other while we, the people, are running down the streets just trying to live our lives and not get pummeled by these two monsters.

This bill cuts through all of that. We have the largest negotiators, the strongest entities negotiating at the federal government level for ten drugs to produce a negotiated price. This is what A.B. 250 does. It is not a complicated issue. This situation simplifies it.

One of the things mentioned today was to wait on this and do it later. Wait for the federal government results first. By 2026, other states will be doing this: Maine, Colorado and Connecticut. There are other states right now enacting similar bills. We are not the only State doing this; we are just the first. We are the most direct about doing it.

Like Ms. MacMenamin, I look forward to working on issues with the PBMs and other long-term sustainable healthcare fixes. But what we have right now is a solution that cuts through all of that. It is negotiated and argued at the federal level that we provide relief for people in this State.

MS. MARSHALL:
In the discussion about R&D, I said pharmaceutical manufacturers spend two to three times more on marketing than on R&D. The CBO report said that there would be two less therapies developed over the course of ten years.

The IRA does consider the fact that pharmaceutical manufacturers need to recoup their costs. That is why a drug has to be on the market for at least 7 years and up to 13 years, depending on the type of drug.

You heard from some of the pharmacy representatives. Section 1, subsection 2 of the bill has an exclusion for the pharmacies' dispensing fee. They are allowed to recoup their dispensing cost. That is written into the bill.

It is the Medicare-negotiated price plus the dispensing fee, and they get to set that fee. That is not set in the bill. Different pharmacies have different costs depending on their volume.

You also heard a lot of "wait and see" this morning. Do not wait and see when we are talking about patients' lives.

ASSEMBLYWOMAN CONSIDINE:
If we, as one small State trying to help Nevadans, cannot pass something being negotiated by the strongest and biggest entities in our Country, what can we do to provide additional healthcare help for the people in Nevada?

SENATOR HAMMOND:
I agree with the Chair. Thank you for taking us to school. You went back and you said, hey, this is what the IRA did. This is the open market. We are talking about markets. You are talking about choice.

I understand the timeline. This fall, we will have the list of negotiated drugs. But when will we have a price? The Legislature meets again in 2025. Will there be a negotiated price for those ten drugs by then, or will that be after they meet?

MS. MARSHALL:
The timeline is that this September 2023, they choose the ten drugs. Then next September 2024, before the Session, they choose the price. The reason they are doing it that way is that it takes time.

As you have heard from various entities, it will take time to then start to negotiate. I did call some hospital associations and doctors associations prior to the hearing on the Assembly side. They told me that, on average, those contracts are for three to five years.

If you open the contract and say, all right, we have this Medicare-associated price, and the manufacturer is required to make sure that medication is available for distribution at the patient level, how are we structuring that? That takes time.

In Nevada, we often do studies. I am sure everyone has their own view about studies. We have an opportunity here to enact this bill, and then in two years, everyone comes to the table with things that need to be improved. We would look at that. We would have that time just like the federal government. If we wait until 2025, there will only be six months to do it.

CHAIR SPEARMAN:
With that, we will close the hearing on A.B. 250.

CESAR MELGAREJO (Policy Analyst):
I will note for the Committee members that A.B. 218 and A.B. 392 have been removed from today's work session. They will be rescheduled later.

ASSEMBLY BILL 218 (1st Reprint): Revises provisions governing landlords and tenants. (BDR 10-136)

ASSEMBLY BILL 392 (1st Reprint): Makes various changes relating to property. (BDR 10-209)

CHAIR SPEARMAN:
We will open the work session on A.B. 110.

ASSEMBLY BILL 110 (1st Reprint): Makes revisions governing the dispensing and delivery of certain dialysate drugs and devices used to perform dialysis. (BDR 54-616)

MR. MELGAREJO:
I have a work session document (Exhibit L) that describes the bill and its history. There were no amendments.

SENATOR PAZINA MOVED TO DO PASS A.B. 110.

SENATOR STONE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
I will open the work session on A.B. 124.

ASSEMBLY BILL 124: Revises provisions governing the renewal of a license as an osteopathic physician or physician assistant. (BDR 54-525)

MR. MELGAREJO:
I have a work session document (Exhibit M) that describes the bill and its history. There were no amendments.

SENATOR BUCK MOVED TO DO PASS A.B. 124.

SENATOR SCHEIBLE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 127.

ASSEMBLY BILL 127 (1st Reprint): Revises provisions governing Medicare supplemental policies. (BDR 57-467)

MR. MELGAREJO:
I have a work session document (Exhibit N) that describes the bill and its history. There was one amendment.

SENATOR LANGE MOVED TO AMEND AND DO PASS AS AMENDED A.B. 127.

SENATOR DALY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 223.

ASSEMBLY BILL 223 (1st Reprint): Revises requirements relating to collection agencies. (BDR 54-755)

MR. MELGAREJO:
I have a work session document (Exhibit O) that describes the bill and its history. There were no amendments.

SENATOR DALY MOVED TO DO PASS A.B. 223.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 298.

ASSEMBLY Bill 298 (1st Reprint): Revises provisions governing housing. (BDR 10-249)

MR. MELGAREJO:
I have a work session document (Exhibit P) that describes the bill and its history. There were no amendments.

SENATOR LANGE MOVED TO DO PASS A.B. 298.

SENATOR DALY SECONDED THE MOTION.

SENATOR STONE:
I regret that I will not be able to support this bill because it imposes some rent controls that I think will potentially decrease investment.

SENATOR BUCK:
I will also be voting no.

THE MOTION PASSED. (SENATORS BUCK, HAMMOND AND STONE VOTED NO.)

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CHAIR SPEARMAN:
I will open the work session on A.B. 401.

ASSEMBLY BILL 401 (1st Reprint): Revises provisions governing schools of nursing. (BDR 54-1042)

MR. MELGAREJO:
I have a work session document (Exhibit Q) that describes the bill and its history. There were no amendments.

SENATOR PAZINA MOVED TO DO PASS A.B. 401.

SENATOR BUCK SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 410.

ASSEMBLY BILL 410 (1st Reprint): Revises provisions relating to industrial insurance. (BDR 53-1030)

MR. MELGAREJO:
I have a work session document (Exhibit R) that describes the bill and its history. There was one amendment.

SENATOR PAZINA MOVED TO AMEND AND DO PASS AS AMENDED A.B. 410.

SENATOR SCHEIBLE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 415.

ASSEMBLY BILL 415 (1st Reprint): Revises provisions relating to dispensing opticians. (BDR 54-846)

MR. MELGAREJO:
I have a work session document (Exhibit S) that describes the bill and its history. There were multiple amendments.

SENATOR STONE:
I just want to thank the proponents for working with me and accepting my recommended amendments to the bill.

SENATOR DALY MOVED TO AMEND AND DO PASS AS AMENDED A.B. 415.

SENATOR PAZINA SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 437.

ASSEMBLY BILL 437: Limits the amount a provider of health care may charge for filling out certain forms associated with certain leaves of absence. (BDR 54-670)

MR. MELGAREJO:
I have a work session document (Exhibit T) that describes the bill and its history. There was an amendment.

SENATOR LANGE MOVED TO AMEND AND DO PASS AS AMENDED A.B. 437.

SENATOR DALY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the work session on A.B. 442.

ASSEMBLY BILL 442 (1st Reprint): Revises provisions relating to persons licensed by the Board of Medical Examiners. (BDR 54-1055)

MR. MELGAREJO:
I have a work session document (Exhibit U) that describes the bill and its history. There were several amendments.

SENATOR LANGE MOVED TO AMEND AND DO PASS AS AMENDED A.B. 442.

SENATOR DALY SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR BUCK VOTED NO.)

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CHAIR SPEARMAN:
That ends the work session. I will open the hearing on A.B. 439.

ASSEMBLY BILL 439 (1st Reprint): Revises provisions governing certain contracts of insurance. (BDR 57-1044)

JAMIE COGBURN (Nevada Justice Association):
We submitted a slight amendment (Exhibit V) that clarifies who is an insured person under the contract. The purpose of the bill is to give insured persons and health insurance companies a voice and a choice. This bill only addresses arbitration agreements between health insurance companies and their insured persons if there is a disagreement.

We, as consumers, really have few choices over who our health insurance carriers are. Usually, it is provided by our jobs. We have no choice to say I do not want this; I do not want to arbitrate and negotiate that clause. Accordingly, this bill amends the statute to say you can go to arbitration, but it cannot be binding arbitration. You have the right of other options available to you. Ultimately, consumers are at the mercy of their health insurance.

Earlier, the Lieutenant Governor gave a heartfelt speech about her issues. Some of that was related to insurance. There are disputes about whether medical treatment is covered by insurance.

Many treatments are extremely expensive. Sometimes, you must go out of State. If you have that dispute, as it currently stands, you are stuck going to arbitration, if there are arbitration provisions.

In about 90 percent of these arbitration agreements, the health insurance companies have created an arbitration program, which they fund 100 percent. If the arbitrators are completely funded by the insurance company, and they are the only resource for that company to do arbitrations, which way are those arbitrators going to rule?

This bill levels the playing field somewhat in that it gives the consumer a choice on how to proceed.

SENATOR DALY:
Would this eliminate arbitration as a binding method of the dispute resolution process? Without it being binding, I do not know why you would engage in it. Will people end up going to court more often? Is there more potential for mediation versus arbitration? How often do you think people will just skip everything and go to court?

MR. COGBURN:
I do not think it will increase the number of lawsuits. It will allow a consumer to say we can do nonbinding arbitration. Ultimately, you would be better off doing mediation, in my opinion. But you would have the right to do a nonbinding arbitration.

It allows you, the consumer, to say, "I would like to use a fair arbitration company." The biggest one is probably JAMS, which provides mediation, arbitration and alternate dispute resolution services.

You would have a say about which arbitrator is used. You can say you want the arbitration subject to certain regulations and rules, not just random arbitration clauses in the contract. But the consumer would still have the right to skip over arbitration and sue. I do not think that will happen often except in egregious cases, but the consumer would have that choice.

SENATOR DALY:
The consumer can say, "I am still going to arbitration. I am still going to do and agree to binding arbitration." But instead of going through the insurance company's arbitrary process where it has already selected the arbitrators, the

consumer can go to the American Arbitration Association and get a panel of arbitrators for each side. That would be agreed to. It would not be in a contract, but it would be agreed to if you went to the alternative resolution. I agree mediation is probably the better road.

MR. COGBURN:
You would still have the option to say you do want binding arbitration. There is no doubt that many times arbitration is quicker. As a practicing lawyer, we will sometimes stipulate arbitration to get something expedited, as long as certain parameters are put in place to make it fair. Each side gets to arrange an arbitrator, and we feel it is a fair process. That is the purpose behind the bill.

SENATOR DALY:
For those going to arbitration, this eliminates the insurer saying, "We are going to arbitration, and you have to use our process." Instead, there would have to be some dialogue to agree on the arbitration process, who the arbitrators are and how they are selected. It would not just be one-sided arbitration that is already negotiated in a contract between an insurer and a provider.

MR. COGBURN:
That is correct.

SENATOR STONE:
Can you tell us about federal law? Is there a federal preemption you are discounting?

MR. COGBURN:
The original bill was going to have a federal preemption issue that made it subject to the Federal Arbitration Act (FAA). We amended the bill and struck out many of the other arbitration provisions requiring it to be nonbinding.

The McCarran-Ferguson Act, 15 USC sections 1011 through 1015, say that the business of insurance is not subject to the FAA. That has been upheld among circuit courts. We do not believe it will be subject to preemption and the FAA.

CHAIR SPEARMAN:
Sometimes when you go through arbitration, additional facts are revealed. That could be a byproduct of making sure the insured has an opportunity to present the other side of the story, unfiltered.

MR. COGBURN:
If you went through a nonbinding arbitration, facts could come out in testimony. In my experience, certain arbitration provisions really limit the amount of discovery allowed. You might get ten questions, or you can take one deposition, or you cannot take any depositions. It becomes hard to uncover certain facts. When you are stuck in an arbitration agreement you had no right to negotiate, you are stuck with it.

Under this bill, the arbitration agreement can be negotiated. You can say, I am fine with binding arbitration, but I want to do it pursuant to *Nevada Rules of Civil Procedure*. That might allow multiple depositions and certain other things. That is really the point. It levels the playing field. It allows you to do discovery, and it allows the consumer to have a choice.

HELEN FOLEY (Nevada Association of Health Plans):
We are concerned about this issue. The Nevada Association of Health Plans is a Statewide trade association representing ten member companies that provide commercial health insurance and government programs to Nevadans. Our mission is to ensure the growth and development of a high-quality and affordable healthcare delivery system throughout the State.

We share the following key points from *ATT Mobility LLC v. Concepcion,* 563 U.S. 333 (2011) as verification of a federal ruling that states are preempted from passing laws that eliminate or limit arbitration clauses.

The FAA has been law since 1925 in response to judicial disfavor toward arbitration agreements. Section 2 of the Act provides a written provision in a contract evidencing a transaction involving commerce to settle by arbitration; a controversy thereafter arising out of such contract or transaction shall be valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

It goes on to say in line with these principles, courts must place arbitration agreements on an equal footing with other contracts and enforce them according to their terms.

When State law outright prohibits the arbitration of a particular type of claim, the analysis is straightforward. The conflicting rule is displaced by the Federal Arbitration Act.

Mr. Cogburn discussed some of these issues. He said we would still have the right to do these things, and under the new amendment, it would no longer be unconstitutional. However, I cannot find that anywhere in his proposed amendment. We do have a problem with this, and we look forward to collaborating with you and others in the Committee to hopefully resolve this issue.

TRAY ABNEY (America's Health Insurance Plans):
I am here today representing America's Health Insurance Plans nationwide trade group. I agree with the comments Ms. Foley made.

We are always concerned about the cost of health care. You have spent almost two hours in this room this morning talking about the increasing cost of health care and the difficulty of affording it.

We are always concerned about any bill that would expose our members to more lawsuits in general. You will find that any time you do that, it does not result in lower costs.

It is not just one client or patient having that issue; it goes through the entire system. It could increase costs for everyone. For those reasons and the reasons Ms. Foley stated, we oppose this bill.

Remainder of page intentionally left blank: signature page to follow.

CHAIR SPEARMAN:
We will close the hearing on A.B. 439 and open it for public comment. Hearing no public comment, we are adjourned at 10:25 a.m.

RESPECTFULLY SUBMITTED:

Kelly K. Clark,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 250	C	6	Assemblywoman Venicia Considine	Proposed drug list
A.B. 250	D	6	Kate Marshall	Timeline for IRA price negotiations
A.B. 250	E	7	Assemblywoman Venicia Considine /	Conceptual amendment
A.B. 250	F	22	Ariel Guevara	Support letter by Elizabeth Yanez
A.B. 250	G	24	Senator Pat Spearman	Letters in opposition
A.B. 250	H	25	Dharia McGrew / PhRMA	Letter in opposition
A.B. 250	I	26	Jimmy Lau / Biotechnology Innovation Organization	Letter in opposition
A.B. 250	J	27	Adam Porath / Nevada Society of Health System Pharmacists	Letter in opposition
A.B. 250	K	29	KayLynn Bowman / Nevada Pharmacy Alliance	Letter in opposition
A.B. 110	L	35	Cesar Melgarejo	Work session document
A.B. 124	M	36	Cesar Melgarejo	Work session document
A.B. 127	N	36	Cesar Melgarejo	Work session document
A.B. 223	O	37	Cesar Melgarejo	Work session document
A.B. 298	P	37	Cesar Melgarejo	Work session document

A.B. 401	Q	38	Cesar Melgarejo	Work session document
A.B. 410	R	38	Cesar Melgarejo	Work session document
A.B. 415	S	39	Cesar Melgarejo	Work session document
A.B. 437	T	39	Cesar Melgarejo	Work session document
A.B. 442	U	40	Cesar Melgarejo	Work session document
A.B. 439	V	40	Jamie Cogburn / Nevada Justice Association	Proposed amendment