MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
March 31, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:03 a.m. on Friday, March 31, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E 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:

Senator James Ohrenschall, Senatorial District No. 21

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bryan Fernley, Counsel
Veda Wooley, Counsel
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Hannah Grauso
Lucy Laube, National Psoriasis Foundation
Heidi Englund
Chris Noellert, The MS Invincibles

Vivian Leal, National Multiple Sclerosis Society
Sarah Watkins, Nevada State Medical Association
Calvinia Williams, President, Lupus of Nevada
Bryan Wachter, Retail Association of Nevada
Cari Herington, Nevada Cancer Coalition
Shawn Navarro
Sean McCoy
Patrick Frase, National Psoriasis Foundation
Erin Rook
Paul Young, Pharmaceutical Care Management Association
Cari Eaton, Chief Financial Officer, Public Employees' Benefits Program
Lea Case, Nevada Public Health Association
Tess Opferman, Nevada Women's Lobby
Marco Rauda, Americans for Contraception
Serena Evans, Nevada Coalition to END Domestic and Sexual Violence
Helen Foley, Nevada Association of Health Plans
Connor Cain, Nevada Bankers Association
Sandy O'Laughlin, Division of Financial Institutions, Nevada Department of Business and Industry

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 194.

SENATE BILL 194: Revises provisions relating to step therapy protocols. (BDR 57-885)

SENATOR JAMES OHRENSCHALL (Senatorial District No. 21):
This bill has the potential to benefit our constituents who are fighting illnesses. It is aimed at expanding and streamlining the process of requesting exemptions from step therapy protocols for prescription drugs, as well as ensuring that these protocols are based on solid medical and scientific evidence.

As most of you know, step therapy, sometimes called "fail first," is a practice used by insurers that requires patients to try lower-cost medications before allowing them the more expensive treatments prescribed by their doctors. For commercial or private health insurers, increased costs because of expensive treatments lowers the potential revenue that might be gained, which also leads to increased premiums for patients. However, it is not guaranteed that cost savings achieved by step therapy will reach the insured through lower premiums or reduced copays.

Healthcare practitioners usually prescribe the most effective treatment for their patients, but they may not place a priority on prescribing lower-cost treatments. Healthcare practitioners may simply not have the pricing information from the patient's health insurance to be able to prescribe more inexpensive but still effective treatment. Health insurers list the prescription drugs they cover in lists called formularies. Some health insurers divide these lists into preferred or nonpreferred, while others use a tier system. In a tier system, prescription drugs are categorized by type, such as generic, preferred brand name, nonpreferred brand name and specialty. Often patients pay the lowest copay for drugs listed in the lowest tier and the highest in the top tier.

Cost is justifiably at the forefront in discussions concerning step therapy reform. The most common concern of legislatures is how reform will impact premiums for constituents and the state. A 2019 analysis of silver-level plans in states where step therapy reform laws have been enacted found that there was no change in the cost of premiums in those states compared to states without such laws.

I believe S.B. 194 will accomplish many of the goals we have seen in other states in trying to help our constituents. It addresses concerns related to insurance companies' step therapy protocols that can sometimes result in delays or denial of necessary treatments for patients, especially those with serious conditions. Existing law already enables patients to request an exemption from step therapy protocols established by their insurers for prescription drugs used to treat symptoms related to late stage cancer. This is based on the groundbreaking work of my colleague, Senator Lange.

Senate Bill 194 proposes to extend this provision requiring certain private sector insurers to create a process for insured individuals and their attending practitioners to request an exemption from any step therapy protocol, as well as to appeal a decision regarding that request. Under S.B. 194, those insurers would be required to either grant the request, if the attending practitioner submits adequate justification for the exemption, or gives a good reason why it is being denied. Furthermore, the bill mandates that this exemption process and the submission of an appeal would be accessible via the insurance company's website.

In addition to expanding the exemption process, S.B. 194 ensures that private-sector insurers use guidelines based on medical or scientific evidence when developing step therapy protocols. This is an important measure to guarantee that patients receive the most effective treatments based on the best available evidence.

This bill also empowers the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization (HMO) or other health insurers that fail to comply with the requirements set forth in the bill. This bill does not extend to Medicaid or managed care organizations.

HANNAH GRAUSO:
I am here to talk about the dangers of step therapy.

I was diagnosed with ulcerative colitis when I was two years old. For years, we tried several treatments, including a biologic named Remicade. None of that worked, and at the age of eight, my parents and I made the difficult decision for me to have my entire large intestine removed. For a few years, I was lucky enough to have no symptoms. Then, around my sophomore year of high school, my symptoms returned, and in 2018 I was officially diagnosed with Crohn's disease. That meant the next step was to begin figuring out a medication regimen. For the next several months, I had debilitating symptoms that often stopped me from attending school or having any form of social life. For those of you who do not know, the symptoms were not pretty: stomach pain, nausea, joint pain, weight loss and more.

This was where step therapy came into my life. My doctor wished to prescribe Stelara to treat my Crohn's disease, but my insurance would not let him due to the high cost. Instead, my insurance required him to prescribe Humira. As it happens, Humira is unlikely to work if Remicade has already failed for you. Due to step therapy, I was forced to spend almost a year of my life taking a medicine that my doctors, my parents and I knew would not work That year was one of the worst times of my life. My symptoms got worse. I was unable to attend school and had to get on a 504 plan due to the amount of school and extracurriculars that I was missing.

For those of you who have children, imagine watching them suffer and knowing you can do nothing about it. Then imagine knowing that there is a medicine that can help them, but your insurance will not let them have it. That is how my parents and countless others felt.

After a year, we were finally able to prove that Humira was not working for me and got approval for Stelara. I was lucky that Stelara was able to help put me into remission. However, a lot of people are not so lucky. For some people, going through step therapy makes symptoms worse, and the medicine they were trying to get no longer works. This means those patients have to go through step therapy all over again. In fact, studies have shown that step therapy has led to an increased risk of hospitalizations and worsening symptoms.

This bill needs to be passed for people like me and for everyone who will end up like me due to the desire of insurance companies to cut costs as much as possible. It needs to be passed so everyone with a chronic illness can get the treatment they deserve and be able to live their fullest lives. It is my hope that this bill will be passed to spare anyone else from going through what I and millions of other patients have had to go through.

LUCY LAUBE (National Psoriasis Foundation):
I represent the National Psoriasis Foundation, and I am also a patient with Crohn's disease. I speak both as a patient and as a staff member for a nonprofit organization.

It is important to note that this bill is built on Senator Lange's incredible work last session in S.B. No. 290 of the 81st Session. We have seen this type of legislation be successful in treatment for late-stage cancer. This bill expands that concept to all disease states so folks with any disease can request an exemption from step therapy. This is critical in the realm of chronic illness, such as those with psoriasis and psoriatic arthritis whom I represent at the National Psoriasis Foundation. If a person with psoriasis goes without their medication, they can develop psoriatic arthritis, which is not reversible. They can also experience more severe symptoms that then cannot be remedied as quickly as they could have been if they had been on the prescription originally prescribed for them.

These decisions need to be made by prescribing doctors and their peers, not by insurance companies. Cost is not the only thing that comes into play when dealing with chronic illness. We need to look at patients' symptoms, what is best for them, what has worked for them in the past and what the professionals believe will work for them now. It is not fair that the patient must try a medication they have already tried that has failed for them in the past or that is expected to fail for them now.

I was diagnosed with Crohn's disease a little over ten years ago. In that time, I tried seven different medications, and six of them did not work for me. I am finally on a medication that has put me into remission, and my health is stable for the first time in my life. If I were to change insurance policies and be subjected to step therapy, there is a possibility that I would have to go back and try those medications that have already failed for me—medications that put me in the hospital or caused flare-ups.

Being on a medication that does not work properly for you can cause severe health effects and potential hospitalization. That does not cut costs. It is more expensive to have to go to the hospital or undergo surgery because your medication did not work than if you had just been on the medication that was prescribed for you in the first place.

SENATOR OHRENSCHALL:
I would like to reiterate that S.B. 194 would not prohibit step therapy protocols completely. It would simply provide a process for asking for an exemption from step therapy.

SENATOR DALY:
I am not going to deny that there are issues with step therapy protocols. However, the way I read this bill, it does not say the insurance company will grant an exemption if the justification is good; it just says they will grant the exemption. If you have tried a drug and it has not worked, I agree 100 percent that you should not have to try it again just because you switched insurance companies. But the way I read this bill, it says the company shall grant the exemption regardless of the justification. You say they can deny the exemption, but I do not see that clearly stated in this bill. I am not saying the insurance companies are innocent. I am just saying that there has to be a fair process.

SENATOR OHRENSCHALL:
If S.B. 194 passes into law, the Commissioner of Insurance will be heavily involved in making sure insurance companies comply with the law. The current step therapy protocols, where patients have to fail first, lead to bad outcomes

for patients. For insurance companies, it is penny-wise and pound-foolish. When patients have negative results and get delayed treatment, it does not lead to cost savings.

The bill was written to be fair to both sides, not banning step therapy but providing both an exemption process and an appeals process. If the Committee has any ideas for amendments, I am open to suggestions.

SENATOR DALY:
The way I read the bill, it says if insurance companies get the request, they shall grant it if there is a statement and documentation. If they received the statement and documentation, they cannot say no. That seems fairly one-sided. If you cannot say no, there is no appeal.

SENATOR OHRENSCHALL:
I am open to discussion on this. I believe S.B. 194 will benefit patients and benefit insurance companies in the long run.

SENATOR DALY:
I will talk with you about this offline.

MS. LAUBE:
I want to note that the language we are using in this bill is model language that has been used in 36 other states, where we have seen it be successful.

I would also note that we included specific language that the insurance company has to grant or deny the exemption rather than just responding. We wanted to ensure that patients would receive a clear answer within that time frame so the process would not be dragged out. We did not want to give them wiggle room. We wanted to hold the insurance companies more accountable and get a clearer and more efficient response from them.

SENATOR DALY:
That is not the way I am reading it. I am happy to talk to you.

SENATOR OHRENSCHALL:
Section 1, subsection 3 of the bill states that a patient shall be exempted from step therapy:

> … if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement.

This language is repeated throughout the bill. The final decision is with the insurer as to whether they believe the practitioner's justification is adequate. I do not think this is one-sided at all. The ball is in the insurer's court as to whether they believe adequate justification has been provided. If the insurer does not feel it is adequate, the only remedy the patient has is to go to the Commissioner of Insurance, even if S.B. 194 passes. We have a great Division of Insurance (DOI), but that is a lengthy process, and it could take months to get the medication you need.

If anything, this bill is one-sided in favor of the insurance company. I wish it went a little further for the insured.

SENATOR STONE:
It is frustrating for the dispenser to have to tell a patient a prescription is not covered by insurance, then call the doctor to find an alternative, only to find the alternative is also not covered. At that point, the doctor gets angry and says, "I'm the one who should be dictating the health care of this patient, not the insurance company."

A family member of mine was treated for depression for over 20 years with a generic antidepressant. They switched insurance companies, and the new pharmacy benefit manager (PBM) said that drug was no longer covered. The appeal process took about a month and a half, during which time the person's medication was paid for out of pocket. When we finally got approval, the insurance company would not allow the dose the doctor ordered, so we had to go through the whole process all over again.

Is there a need for a streamlined process to get drugs covered for patients? Absolutely. Your bill is balanced in the way it is written.

It might alleviate a lot of these issues if the formularies included the cost of each drug. I will compare that to when you go to a fast food restaurant and the menu includes the calorie count of each item. If you get a 12-ounce burrito, it is 800 calories; if you get the 6-ounce burrito, it is 500 calories. If physicians could see that the brand name drug is $1,000 a month and the generic version of that same drug is $25 a month, they can make a therapeutic choice between the two versions of the drug.

I applaud you for writing this carefully. I love the idea of having the website, but technology can be a blessing or it can be a curse.

The only issue I have with the bill is section 10, where it authorizes the Commissioner to suspend or revoke any certificate of authority of an HMO if it fails to comply. That seems draconian. I would like you to consider less severe steps first, such as a letter giving the administrator ten days to fix the problem. If you revoke an insurance company's license, you will have thousands of people with no insurance. If I am misreading this, please let me know.

SENATOR OHRENSCHALL:
I appreciate you sharing your experience as a practicing pharmacist. I have relatives with serious illnesses, and I have seen situations where their healthcare provider has said, "I want you to try this medication." They run down to the pharmacy to pick up that medication, and the pharmacist has to tell them the insurance will not approve it. I have even had situations where my relatives tried to pay cash for the medication, only to have the pharmacist refuse, saying, "Unless the insurance okays it, I won't sell it to you." There is a need for a lot of reform in this field, and S.B. 194 will help.

Regarding section 10 of the bill, that is existing law regarding the powers of the Commissioner. This is the Commissioner's big stick: the ability to suspend the insurance company's activities in Nevada. I believe the actual revocation of someone's license rarely happens, but it is part of the DOI's toolbox to make sure insurance companies comply with our statutes. Section 10 simply adds the provisions for exemptions and appeal regarding step therapy protocol to *Nevada Revised Statutes* (NRS) 695C, which is our HMO statute.

SENATOR STONE:
When you have technological parameters such as a website, what happens if the website goes down? I do not want to see an insurance company get sanctioned due to a technical issue they may not be aware of.

SENATOR OHRENSCHALL:
I am happy to talk with you about this. Perhaps there could be an amendment regarding progressive discipline for insurance companies.

CHAIR SPEARMAN:
We are trying to get someone from DOI on the phone to speak to that.

SENATOR PAZINA:
I had a question about the practicalities of the bill. Section 1, subsection 2, paragraph (c) states the insurer has 72 hours to respond to the request, or 24 hours if there are exigent circumstances. How is this working in the other states who have enacted this legislation?

MS. LAUBE:
That part of the bottled language has been successfully implemented in other states. The purpose of that provision is to make sure the process does not get dragged out.

SENATOR OHRENSCHALL:
We are actually more generous than some states. In Oklahoma, for instance, insurance companies have 24 hours to respond in all circumstances. The intent is that patients not be left to languish. Right now, it can be weeks before the insurance company responds.

SENATOR PAZINA:
I understand the need for that. I was just curious if it was actually happening, and if insurance companies were able to respond in those time limits.

SENATOR OHRENSCHALL:
I have read that it is working, and I think we are going to have some testimony from some healthcare providers in other states who can speak to this.

HEIDI ENGLUND:
I am in support of S.B. 194. I have written testimony (Exhibit C) in support of the bill.

I am part of a group called The MS Invincibles, which is a support group for people with multiple sclerosis (MS). I have heard people talk about paying $800 or $1,000 for prescriptions, but I have never seen those prices in my life. The drug I am currently on is $25,000 a month. I take that pill every night before I go to bed, and if I did not have it, I would be sick again within two months. We are talking about specialty drugs from a specialty pharmacy.

Something is happening with the treatment for MS right now. For the first time, we have a drug, and it has a generic version. The year 1996 was the first time you could be treated for MS. Before that, you were just given a wheelchair, and that was the end of your life. If it were not for AIDS research, I would not have the Betaseron drug that has kept me out of a wheelchair. When I was first diagnosed, it was $50,000 to $60,000 for each pill. I am lucky to be on that drug.

The problem with step therapy is that I could be prescribed a drug I have already been on that has already failed. At one point when I was very sick, I was put on a stronger drug that was administered in an infusion. I went to the infusion center for three hours every month to get that infusion, and it cost up to $80,000 a month because of the bill from the infusion center. With that drug, there is a risk of a fatal brain disease called progressive multifocal leukoencephalopathy. When my blood showed that I had reached a peak of the virus for that disease, they stopped that drug and put me on the pill I am now taking. I was lucky to get to that point.

I have been through five or six different MS therapies. If step therapy was forced on me, they might put me back on some of those drugs I have already been through. With MS, it does not work that way. Each MS drug attacks a different part of your body. It has to shut down a certain part of your immune system, and that is pretty serious. You cannot be bounced between drugs; you just cannot. I had to go through a lot to get a copay card for my current drug. If I am bounced to the generic drug, my copay card will disappear, and I will not be able to afford my drug.

I am on a new insurance plan now. Every year I have to go through Nevada Health Link, which is a privilege; I am glad to be able to buy health insurance. Because of my health insurance, my drug costs around $300 a month. If I had to pay $80,000 a month, I could not afford it.

In my written testimony in Exhibit C, I used the word "sadistic" because of the way we suffer. You do not know how much I suffered when my drug was withheld. I would be out there in the parking lot every day at my job screaming and crying for someone to help me. What happened to me should not have happened to me.

CHAIR SPEARMAN:
We have received a number of letters of support (Exhibit D) for S.B. 194.

CHRIS NOELLERT (The MS Invincibles):
I am the leader of The MS Invincibles support group. One of my members, Jan Kallet, could not be here this morning and asked me to present her letter of support, which can be found on page D12 of Exhibit D.

VIVIAN LEAL (National Multiple Sclerosis Society):
I have written testimony in support of S.B. 194 (Exhibit E) and a chart showing how MS drug prices have risen (Exhibit F).

I have been an MS patient for 22 years. When I was diagnosed, there were just two medications. My medication was $7,850 a month. That exact same medication is now listed in Exhibit F with a price around $80,000. I understand that insurance companies want to control costs, but they should not do that on the backs of patients. They are not the ones who are failing first; they are making record profits and paying their executives a great deal of money. It is the patients who are suffering and failing.

The irony is that the range of medications available has dramatically improved long-term outcomes and delayed disability. Their response to these high prices has been to limit access to them, availing themselves of every excuse. You worry about the insurance companies having too short a time to respond, but they have been giving us the runaround. They currently have ten working days to respond, then ten days to respond to the response.

One of my last challenges was very frustrating. My doctor, who is the head of the Stanford Multiple Sclerosis Center, wanted me on a certain dosing schedule because my medication was not quite doing the job. I was getting into something we call "the crap gap," when your MS symptoms worsen between doses. When my doctor tried to adjust my dosage, it was declined. We filed an appeal, but the insurance company denied it based on the advice of their expert, who is a pediatric oncologist. That was the expert they used to override the advice of my doctor, who has worked on this disease his entire professional life. The drug I am currently on is not the one my doctor wanted for me.

We are not asking for the most expensive drug. We are just asking for the drug that is going to work without being forced to repeat drugs that we already know are going to fail. The main thrust of MS research for the last 20 years has concluded that if you treat early and aggressively, you stabilize the patient, and you get patients who can lead normal functional lives. If you give MS a chance, it pounces, and then what happened to Heidi and Jan happens.

We should be managing MS for longer term outcomes. Yes, that comes with a cost. But the bills to manage our catastrophic situations that were caused by delay have a greater cost. This aggressive weaponized preauthorization system is being wielded against patients to control the cost of the drugs. This bill will not do much about the cost of the drugs, but we can do something about the system that is clearly hurting thousands of Nevadans.

SARAH WATKINS (Nevada State Medical Association):
We are in support of S.B. 194.

CALVINIA WILLIAMS (President, Lupus of Nevada):
I am here in support of S.B. 194.

I have had lupus for 23 years. It made me blind when I first had it, and I did not think I was ever going to see again. My doctors worked hard when I got to Las Vegas 20 years ago, and we started Lupus of Nevada so we could work together and fight for what we needed. I visit my friends in the hospital, and when I leave I sit in the hall and just cry. The doctors ask me what is wrong, and I say, "My people are dying."

My doctor works hard for me. Once he authorized a drug for me, and the insurance company said they were going to give me something else instead. My doctor called them and said, "She will get the drug she needs. I’m not playing with you insurance companies; this woman has major problems, and it will be what it is." Not every doctor can do that.

We are just trying to survive. We love what you do, and we appreciate everything you can do for us, because you have made a change in our lives.

BRYAN WACHTER (Retail Association of Nevada):
On behalf of our pharmacy members, we are in support of S.B. 194.

Often, it is pharmacy employees who are the front line in this battle. It is our employees who have to deal with the frustration of patients who are trying to navigate a complicated system. It is frustrating to have a medication in stock that we know will probably work but be unable to dispense it.

We think the limited scope of S.B. 194 is good, and we look forward to its passage.

CARI HERINGTON (Nevada Cancer Coalition):
We are strongly in support of S.B. 194.

We were grateful that Senator Lange addressed this for our stage 4 cancer patients last Session, and we would love to increase it to cover anyone with cancer at any stage. With today's technology and the advances that have been made, treatment and care are individualized. No one's cancer is exactly the same as another's, so failing first on a medication or treatment could mean life or death for people with cancer.

SHAWN NAVARRO:
I am here to testify in favor of this bill. The testimony we have heard so far makes it clear that these people are more than claims, more than names on spreadsheets. These are real people with real stories and real families.

I was unexpectedly hospitalized for two weeks this past January with emergency gallbladder surgery. The experience taught me that with our current medical system, you either need someone to advocate for you or you have to learn to advocate for yourself. A lot of folks in the Latino and immigrant communities do not have that kind of advocate. They find it difficult to navigate the Byzantine system we currently have between doctors, pharmacists and insurance companies. Anything that helps streamline the process is good.

SEAN MCCOY:
I support S.B. 194.

I am here on behalf of my family. Fortunately, we did not have to fail first. We were diagnosed with Crohn's disease and were able to get on Stelara right away. However, we have had to stay on our current insurance, which is that offered by the Consolidated Omnibus Budget Reconciliation Act (COBRA). The concern is that any change in insurance could require us to go back and "fail first" after we have already been successful on the current drug we are on. If S.B. 194 does not pass, when our COBRA insurance runs out, we could be forced to go back to step therapy. Our doctor informed us that the issue with biologics is that if you stop them for a year, they may not work the next time you try them. We do not want to be stuck in a situation where we are no longer allowed to be successful and thrive. We have only to stop once for our chance to fail.

PATRICK FRASE (National Psoriasis Foundation):
We support S.B. 194.

I am the loan advocate volunteer for the Psoriasis Foundation in Las Vegas. There are some 30 odd autoimmune diseases, and they are all represented here today. I myself am also a psoriasis patient, but I was blessed by being able to do seven years of clinical trials as an official guinea pig. I did step therapy within my clinical trials. I went through three different pharmaceuticals that are all now on the market. My out-of-pocket is currently zero, but that is probably going to change.

ERIN ROOK:
I am here to support S.B. 194.

As someone living with multiple chronic illnesses, I too have experienced unnecessary delays in accessing physician-prescribed treatments due to step therapy protocols. I primarily had this experience in relation to medication for attention-deficit/hyperactivity disorder. The step therapy protocols meant that I had to try multiple less expensive medications before my insurance would approve the prescription my provider knew would be most effective for me. During that time, I experienced challenging side effects. It was rough.

What I really worry about is facing this same battle over my serious health conditions. I have a type of inflammatory bowel disease called ulcerative colitis. I also have a chronic autoimmune condition called hidradenitis suppurativa, for which the primary treatment is a biologic. I have been lucky to not yet need medications that require that prior authorization. I expect that will be part of my future. As many folks have said, it is important for people to realize that patients with these types of diseases risk serious and even fatal outcomes if not properly treated. The worst outcome the insurance companies risk is a decrease in profits.

I recently visited my gastroenterologist after being off medication due to a lack of insurance. She told me that I was playing with fire and was at an increased risk of colon cancer every day I went without taking my maintenance medication. This is an issue that impacts my husband as well. His rheumatoid arthritis requires expensive biologic medications, and without them he is not able to work or even do something as simple as opening a door.

Patients already experience enough barriers to accessing care. The least we can do is make it easier to access the medication the doctor prescribes.

I urge you to support S.B. 194 to help ensure that patients have the ability to access appropriate medical care.

PAUL YOUNG (Pharmaceutical Care Management Association):
We are opposed to S.B. 194 in its current form.

We would like to thank Senator Ohrenschall for bringing this important bill. We understand the concerns of everyone who spoke, and we look forward to working with Senator Ohrenschall.

CHAIR SPEARMAN:
Have you talked with him about your concerns?

MR. YOUNG:
Yes, we are working together.

CARI EATON (Chief Financial Officer, Public Employees' Benefits Program):
The Public Employees' Benefits Program (PEBP) Board has reviewed this bill and has voted to take a neutral stance.

Step therapy is a common cost-control measure used by insurance plans, including PEBP, to steer patients to medically equivalent yet less costly drugs before moving to higher cost drugs. Although approximately 40 percent of patients tend to stay with the lower cost medication, PEBP recognizes that step therapy may also result in delays to care for those who do not see results through lower cost drugs. The use of step therapy protocols enables PEBP to save an estimated $3 million annually. These savings are passed back to the members, which in turn helps control rising employee premium costs.

Although this bill establishes an appeal process that PEBP already has in place, the final say ultimately lands on the provider, which is projected to reduce the volume of step therapy cases by up to 40 percent. This is anticipated to drive costs up by a projected $1.5 million per year.

CHAIR SPEARMAN:
What is the average age of your beneficiaries?

MS. EATON:
I do not know. I will get that information to the Committee.

CHAIR SPEARMAN:
I would like to ask counsel whether this bill would affect PEBP or plans under the Employee Retirement Income Security Act of 1974 (ERISA).

BRYAN FERNLEY (Counsel):
This bill would apply only to private insurers, so it would not apply to PEBP, ERISA or local government plans. That is because NRS 287.04335 sets forth which sections apply to PEBP. This bill does not amend that section to include these provisions as applicable to PEBP. Also, this bill would not affect ERISA plans because states are preempted from regulating those plans by federal law.

SENATOR LANGE:
Following up on that, would Medicaid be covered?

MR. FERNLEY:
No. Section 12 of the bill specifies that section 11, which includes the provisions applicable to managed care organizations, do not apply to recipients of Medicaid. It is only private insurers.

SENATOR LANGE:
Senator Ohrenschall, I would really encourage you to take a look at that. We are leaving out a lot of Nevadans by not covering Medicaid.

SENATOR OHRENSCHALL:
I am open to any amendments that would make the bill better and protect more of our constituents.

I want to thank Hannah and Lucy for sharing the struggles they went through, as well as everyone else who testified. I believe this bill is written in a way where the two words "adequate justification" would be in the insurers' favor and allow them to decide whether adequate justification has been met for exemption from step therapy.

This bill does not abolish step therapy; it merely provides a process for patients and physicians to request an exemption. If the exemption is denied, patients can go to the Commissioner of Insurance for redress. I believe the bill really does look at both sides, protecting both the patient and the insurance company.

I am open to amendments to expand the bill. I do not believe it covers PEBP, and thus the fiscal note for $3 million is in error. I hope that means the fiscal note will be removed.

MS. LAUBE:
I would like to add that the Safe Step Act is currently being considered in the U.S. Senate, with support from Senators Jacky Rosen and Catherine Cortez Masto.

I want the Committee and whoever is listening to understand what it means to have a medication fail, what it means to be a person with a chronic illness. It is not just having a cold, feeling under the weather or missing a couple of days of work. Failing a medication can mean hospitalizations; it can mean procedures. It can mean a lot of pain and missing long periods of school or work. It can mean irreversible damage, such as being bedridden or unable to leave the house. It is challenging to live with a chronic illness, and it impacts every aspect of your life, financially, emotionally and physically. To go through all that while there is a medication that will work for you and you just cannot have it adds to the suffering.

I want you all to sit with that and understand what it means to be a person with a chronic illness. Why is that the price we have to pay for insurance companies to reduce their costs?

MS. GRAUSO:
I wanted to note the effects that step therapy has. My entire body has been wracked by this disease, and that is largely due to the length of time it took for

me to get adequate care. I have pinched nerves in my shoulders from hunching over from stomach pain. I have chronic joint pain.

Step therapy does a lot of damage because it means months or even years in which you are not getting adequate care. It is important to note the effect it has on real people and constituents.

CHAIR SPEARMAN:
Who submitted the fiscal note?

SENATOR OHRENSCHALL:
The fiscal note is from PEBP, but since the bill does not touch on NRS 287, which covers PEBP, I believe it is in error and will be removed.

CHAIR SPEARMAN:
Ms. Eaton, please get together with Senator Ohrenschall and figure this out.

I will close with a quote from Maya Angelou: "I think we all have empathy. We may not have enough courage to display it."

I will close the hearing on S.B. 194 and open the hearing on S.B. 352.

SENATE BILL 352: Revises provisions relating to prescription drugs. (BDR 57-134)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
Before Senator Stone presents the bill, I want to give you some of the context and history of this bill.

Here in Nevada, we have been working for a long time to ensure everyone has adequate access to necessary health care, including contraceptives. In 2017, we required that insurance companies cover 12-month prescriptions for contraceptives. In 2019, we required that contraceptives be made available over the counter, and we confirmed that in 2021. Nevada law already requires that those wishing to receive a birth control prescription in Nevada be able to get it for 12 full months on their insurance plan.

We also ensured that a pharmacist would be able to prescribe that medication directly so those who require hormonal contraceptives would not have to make multiple appointments with their provider for what is in most cases a simple process. Certainly, for some people, finding the right birth control can be complicated. For many of us, however, it is as simple as getting one prescription for one pill, ring or patch. Once we find the one we like, we keep renewing that prescription for years and even decades. For all of those cases, we have tried to create a system in Nevada where you find your preferred form of birth control and can be prescribed that birth control for a full 12 months, then go to the pharmacy and get that 12-month supply.

Unfortunately, we have learned that this is not being implemented the way we intended. Over the last two years, I have worked with a couple of partner organizations to figure out why that is. This Session, I am lucky enough to have a colleague who is a pharmacist who understands this issue much better than I do. We discovered that a couple of different things were getting in the way of people being able to pick up a 12-month prescription the day they walked into the pharmacy. It has to do with PBMs and insurance companies. Even though they are required to cover these prescriptions, they were only prescribing them for three months at a time because we had included a provision allowing the first prescription to be only three months long. Twelve months after that, when people were switching insurance, the insurance companies were starting over with that three-month prescription. Sometimes the PBMs were interpreting the law in a different way and not allowing pharmacists to fill those prescriptions for the full 12 months.

That is why we bring S.B. 352 to you today: to close the loopholes, clean up the language and ensure that every person in Nevada can go to their pharmacist, be prescribed 12 months of contraception and receive all 12 months at one time.

SENATOR JEFF STONE (Senatorial District No. 20):
This bill will expand the number of providers who can provide oral contraceptives to patients by authorizing pharmacists to make such orders. It further codifies the responsibilities of PBMs by stating they must comply with the same provisions of the Nevada Insurance Code as insurers do.

Furthermore, this bill will not let insurers or the PBMs they contract with require prior authorization. You can legally get these medications, and you should not have to go through any more steps to get them, especially for emergency contraception.

Finally, this bill requires Medicaid and private insurers that are contracting with PBMs to allow the dispensing up to a 12-month supply of the oral contraceptives.

As we have all heard, we have a shortage of primary healthcare providers in Nevada, especially in the rural areas. This bill will expand access to oral contraceptives, including emergency contraceptives, that a patient would typically get by going to a physician or other practitioner. This bill will expand accessibility to 24 hours a day, 7 days a week.

I would like to go over the bill. I will be referring to our conceptual amendment (Exhibit G) throughout.

Section 1 says a PBM who manages prescription benefits for an insurer is required to comply with the same provisions of the Nevada Insurance Code as the insurer. In other words, PBMs are held to the same standard as insurers in following through and making sure patients get the medications they need.

In section 2, we recommend inserting new subsections 1 and 3 that you can see in Exhibit G. They essentially state that the insurance company will let patients know which of their pharmacies have an actual pharmacist available, rather than just dispensing. A patient can go to a pharmacy at three in the morning and say, "I need some emergency contraceptive to prevent a pregnancy," and the pharmacist would be authorized to do so.

In section 15, subsection 1, Exhibit G adds paragraph (b), which refers to a patient who has already been maintained on an oral contraceptive without any problems. This is like getting a refill. For patients who are being prescribed oral contraceptives for the first time, we limit that first prescription to a three-month supply in case they have a reaction to the medication or its side effects. We did not want to obligate the insurance company to pay for a full year of medication in case most of it is discarded. If the patient tolerates the medication after three months, a further nine-month supply of the prescription would be issued.

SENATOR BUCK:
If a contraceptive is successful for a year, can a patient have the doctor call in a renewal, or do they have to actually go to a visit with their doctor?

SENATOR STONE:
We always encourage patients to confer with their doctors, but they do not need to. They can actually ask the pharmacist to authorize the 12-month supply on January 1. They do not have to make an appointment with the doctor.

SENATOR BUCK:
Can patients do this for five or ten years, or as long as they want?

SENATOR STONE:
The pharmacist is going to be asking questions. They are not going to just give a prescription to somebody without doing a drug history and maintaining a record. But yes, the patient can do this in perpetuity.

SENATOR BUCK:
I love that. How does it work if a person changes jobs and gets new insurance?

SENATOR STONE:
They can just continue on the same medication.

SENATOR DALY:
I do not understand the part of Exhibit G where it says, "Those regulations must not allow a health carrier to demonstrate the capacity to adequately deliver family planning services … " I know you are trying to fix something, but I want to have it explained again.

SENATOR SCHEIBLE:
I had the same question, so I will try to answer your question to see if I understood the explanation. Basically, the Commissioner of Insurance is going to set rules to say pharmacists must prove they are adequately covering people. The sentence you quoted says they have to show that the pharmacies are not just for dispensing the drugs, but that they are also contracting with pharmacists who can prescribe the drugs.

SENATOR STONE:
Senator Scheible explained that perfectly. When you get your annual package from your insurance company, they are going to show you which pharmacies are covered by your plan. This bill will require that the healthcare plans tell you which pharmacies can prescribe as well as dispense, rather than just listing a

bunch of pharmacies and not delineating that some of them only dispense and do not have a pharmacist who can prescribe.

SENATOR DALY:
Thank you. That answers my first question.

My second question was in section 6, subsection 2, paragraph (b), and it might be in other areas as well. I understand that when the network contracts with a pharmacist who can write a prescription, reimbursement cannot be less than they would pay a physician. If pharmacists wanted to contract for less, would they be allowed to? I understand the protection you are trying to get, but would they be able to agree to whatever contract they wanted to make?

SENATOR STONE:
The purpose of section 6 is basically pay parity. A pharmacist provider of a prescription for an oral contraceptive or an emergency contraceptive shall be paid at the same reimbursement rate as a physician providing the same service.

SENATOR SCHEIBLE:
When we learned that people were not able to access their 12-month prescription, the organizations that partnered with us on this did some research interviewing patients, pharmacists and insurers. They found that pay parity was actually one of the issues that was standing in the way. Pharmacists were declining to contract because they were not getting paid at the same rate as doctors and other practitioners. We are trying to fix that problem by ensuring that they would be reimbursed at the same rate. Requiring parity is hopefully going to increase the participation of pharmacists and access for Nevadans.

SENATOR DALY:
Understood.

Regarding Exhibit G, you asked about waiving the copay. I am assuming that if the person got a 3-month supply, they would not be charged a copay for the whole 12 months. When they go back and get the other nine months, they could still have a copay for that; they would not have to waive it. Is that your intent?

SENATOR STONE:
The issue here is that insurance companies charge copays in a different manner. Some charge a copay for one inclusive prescription; some charge a copay for every month that the birth control is given. If they charge one copay and the person is getting three months, we want to basically save the insurance company nine months' worth of contraceptives that the person is not going to use. If they have an adverse reaction, they should not be penalized for getting the second nine months. This helps the insurance companies; they should not be double-dipped with a copay if they charge by the month. It would be prorated for the remaining nine months if they charge a per-month fee for each of those months.

SENATOR DALY:
I understand.

CHAIR SPEARMAN:
The lowest amount is three months. If the patient figures out after two weeks that the medication is not working for them, what happens to the rest of that prescription? Is any cost incurred by the pharmaceutical company?

SENATOR STONE:
If they are having an adverse reaction to the oral contraceptive, they would stop taking it and consult with the pharmacist or physician to get a new prescription. They would then get another three-month supply of the new medication. Unfortunately, they would have to pay the copay again for that new drug. Any leftovers from the first prescription would be discarded.

CHAIR SPEARMAN:
Is there any cost incurred by the pharmaceutical company for that discarded medication?

SENATOR STONE:
The pharmaceutical company is getting paid for the drugs. The insurance company will not be able to take back the unused drug and dispense it to someone else; that is against federal laws. That is true for any type of medication. If you are prescribed a drug for high blood pressure and it does not work for you, the doctor will discontinue it and prescribe a different medication, and you would discard the remainder of the ineffective drug.

CHAIR SPEARMAN:
The subject of emergency contraceptives has triggered discussion in the U.S. about people who have certain religious beliefs refusing to dispense drugs for that purpose. Does anything in this bill change that situation in Nevada?

SENATOR SCHEIBLE:
No. This does not change existing law in Nevada, which requires insurance companies to cover both oral contraceptives and emergency contraceptives and requires pharmacies to dispense them.

LEA CASE (Nevada Public Health Association):
We support S.B. 352. Access to family planning and appropriate contraception use is a pillar of reproductive rights access and justice. I want to get on the record that the Nevada Public Health Association has supported these efforts in the past and continues to support them today.

TESS OPFERMAN (Nevada Women's Lobby):
We support this bill. The Nevada Women's Lobby supported the prior two bills regarding the availability of 12-month contraceptive supplies and the ability of pharmacists to provide contraceptives. Our understanding is that this is not happening in practice. From the list online, it looks like only 24 pharmacies in Nevada are providing contraceptives through the pharmacist assistant, and we would like to increase that access. We appreciate this clean-up bill to ensure that all Nevadans are able to access contraceptives.

MR. WACHTER:
We are in favor of this piece of legislation. The payment parity issue has led to a decrease in access. In fact, some pharmacists have only been accepting cash payments because of this payment issue. We are glad that this bill seeks to address that our community and chain pharmacies are growing, expanding their roles and providing more access to health care. We are appreciative of this and think it is going to lead to a lot of positive health outcomes.

MARCO RAUDA (Americans for Contraception):
We support S.B. 352. It was good to see bipartisan support of this bill. Making it easier for Nevadans to receive prescription dispensing of contraceptives is sensible policy.

SERENA EVANS (Nevada Coalition to END Domestic and Sexual Violence):
We support this bill and echo the sentiments of previous speakers. We worked on the previous bills and are grateful to the bill sponsors for doing in-depth research and figuring out why this was not working in practice. We appreciate this attempt to improve these laws and increase access to contraception.

MS. ROOK:
I support this bill. It is important to ensure easy and equitable access to contraception for all Nevadans. I hope to see more bipartisan collaborations that honor the doctor-patient relationship over politicized discourse that seeks to divide us.

HELEN FOLEY (Nevada Association of Health Plans):
We are currently opposed to S.B. 352. Some of our members have been working with Senator Scheible, and we are close to working out an agreement with her.

SENATOR STONE:
I would like to respond to the comment that there are only 24 pharmacies actually prescribing oral contraceptives right now. This is because of the way the laws have been written in the past. The pharmacy can be reimbursed for the ingredient cost of the contraceptives, but there is no reimbursement to the pharmacist for their time in ordering the contraceptives. This bill is going to dramatically increase access because the pharmacy owners are going to be reimbursed for their pharmacist's time to order and dispense these medications.

Pharmacists are some of the most highly educated and underutilized healthcare professionals in Nevada. We have a healthcare shortage, and pharmacists are delighted to step up to the plate with our expertise and help practitioners deliver the health care our citizens need and deserve.

CHAIR SPEARMAN:
I am always conflicted by people who reject the notion that contraceptives should be easily available. They are usually the same people who scoff at increasing funding for education after the children get here.

SENATOR STONE:

> I would like the public to know that I am a licensed pharmacist in California. I do not want anyone to think that this is self serving or that I am going to be operating a pharmacy, making profit for myself. I am kind of retired and I plan on fully retiring very soon. I do not think it was a self-serving interest in participating in this.

CHAIR SPEARMAN:
I will close the hearing on S.B. 352 and open the hearing on S.B. 355.

SENATE BILL 355: Revises provisions relating to financial services. (BDR 55-59)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
We have been working for a year and a half trying to pull together some financial legislation that we thought would be helpful to Nevada. What you are going to hear today is a result of the meetings we had with stakeholders once a month during the Interim.

As we all know, Nevada relies heavily on financial institutions to keep its economy running. These institutions provide vital services to businesses and individuals alike, including loans, savings accounts and investment opportunities. However, the licensing process for these institutions is sometimes seen as overly burdensome and time consuming, which can discourage potential new entrants to the market. This is particularly concerning given the changing nature of the financial sector, with many new fintech firms and online lenders entering the space. Nevada wants to remain competitive in this changing landscape. We must ensure that our licensing process is streamlined and efficient.

Another area that requires attention is regulation of protections for senior citizens and vulnerable persons in Nevada. While there are already regulations in place to protect these consumers and ensure that financial institutions are operating in a safe and sound manner, these regulations must be updated to reflect the changing nature of the industry. With the rise of digital technology, many lenders are now able to provide loans to borrowers without ever meeting them in person. While this can be a convenient option for borrowers, it also raises concerns about fraud and identity theft. There is a need for clear regulations to ensure that remote lending is conducted in a safe and secure manner.

By streamlining the licensing process, updating regulations and ensuring that remote lending is safe and secure, Nevada can continue to attract new entrants into the financial sector and support the growth of its economy.

SENATOR SCOTT HAMMOND (Senatorial District No. 18):
Senator Lange brought the idea for this bill to my attention. It was a pleasure to meet with stakeholders and talk about some areas that would benefit several communities and bring clarity to the institutions.

I will go through the sections of the bill. Section 1 removes the requirement for applicants to provide a physical address for the main office of the proposed depository institution during the licensing process. Instead, the Commissioner of the Division of Financial Institutions can require the applicant to provide a general location and submit a physical address before commencing business operations. This change acknowledges the growing trend of digital and remote banking services and streamlines the application process.

Section 3 of the bill extends the existing provisions governing requirements for a financial institution to report known or suspected exploitation of older or vulnerable persons. These extensions include procedures that a financial institution may take to temporarily delay a requested disbursement or transaction involving an account of an older or vulnerable person.

Section 5 of the bill permits employees of licensed lending businesses to work remotely provided they adhere to certain requirements. This measure adapts to the changing landscape of work, allowing businesses to adapt and innovate in their operations.

Sections 6 through 8 outline additional requirements and restrictions to ensure data security and maintain operational integrity for remote employees.

Section 17 exempts licensed lending businesses from existing data breach notification requirements.

While section 9 establishes specific notification provisions tailored to the financial institution industry in the event of a data breach, the licensee must notify affected residents after discovery of a breach of security of the data.

Section 10 mandates that any licensee required to notify more than 500 residents due to a single breach must also notify the Attorney General.

CONNOR CAIN (Nevada Bankers Association):
I will walk you through the amendment we submitted today (Exhibit H), which we believe is a friendly amendment. We have spoken with the sponsors of the bill.

The intent of the first change is to clarify some of the protections that already exist in law. When they see a suspicious transaction or disbursement, financial institutions and their designated reporters are required to report the transaction to the Aging and Disability Services Division, Nevada Department of Health and Human Services, and to local law enforcement pursuant to section 3, subsection 2, paragraph (a), subparagraph (1). We want to give financial institutions the ability to place a hold on a transaction if they feel it is necessary. That is what this amendment is intended to do.

The second change allows the designated reporter to proceed with the transaction or disbursement once they reasonably believe it will not result in the financial exploitation of the older or vulnerable person. We do not want to delay transactions unnecessarily. The amendment does not change the requirement that the reporter make a report to the Aging and Disability Services Division.

Regarding the third change, the tools used by fraudsters to target seniors and vulnerable persons are constantly evolving. Section 3, subsection 9 lists a number of criteria that a reporter may consider when deciding if someone has been victimized. However, we think it is important to keep these criteria permissive in statute, as this will continue to be a moving target. The third change in Exhibit H changes "shall" to "may" in this section.

SENATOR DALY:
We want to protect people, that is for sure. How do people get notified when their transactions are delayed? The bill says the institution has to notify the customer within two days. Is that by electronic mail or a phone call? It could take quite a bit of time if it gets sent via snail mail. A person might have a

transaction they needed to go through, and it could be five days before they know it has been delayed.

SENATOR LANGE:
Banks already do this. They contact the person by phone right away. If they cannot reach the person, they call a relative to see if they can reach the person. It is important to have that personal contact as soon as possible. I do not know if any of you have ever had your bank account hacked, but I have, and it is not a fun situation. The sooner you can get to the person who owns the account, the better.

SENATOR DALY:
I know you changed the language on the breach so it parallels what is already in law. Can you explain why you did that? I think you took it out of section 17 and added it to section 9.

SENATOR LANGE:
Could you restate the question? I am not sure what you are asking.

SENATOR DALY:
Section 17, subsection 7 says, "The provisions of this section do not apply to a person licensed pursuant to chapter 675 of NRS." That excludes the banking system from the disclosure process, which is already in existing law. It is similar to section 9 of the bill. Why did you make these changes?

SENATOR LANGE:
It was nothing we intentionally tried to make happen. Perhaps our counsel can respond to the question.

MR. CAIN:
I am happy to compare the two sections and send an email to the Committee explaining the differences.

SENATOR DALY:
That works for me. I would like to know the reason for it.

SENATOR STONE:
I would like to give you a real-life example of something that happened to a tenant of mine to illustrate the kind of situation we are trying to prevent. Mr. C

was an 89-year-old veteran who was widowed. He moved into an apartment with his dog and was retired with $150,000 in the bank. He was very lonely until somebody on Facebook took a liking to him. They developed a relationship, and eventually the person said they were having financial difficulties. Mr. C would go to the bank and send five-figure wires to this person. Mr. C was in love, and he wanted to have a long-term relationship with this person. The only question the bank asked was, "Mr. C, do you know the person you are wiring this money to?" He said yes. The bottom line is that over about a three-month period, he wired all $150,000, his entire savings, to this person. He now lives on social security and a small pension, and that is all he has. He filed a police report, and the officer said, "Yes, I'll do the report, but once you wire the money outside the United States, there's no way for us to get your money back."

That is an extreme case, but that is what we are trying to prevent. I am not sure what anyone can do to intervene when people are obstinate. Their attitude is, "This is my lover. I want to send that money, and there's nothing you can do to stop me." They may not have family members to help, and I am not sure we can help someone who takes that stand. Certainly, this legislation helps us get there.

SENATOR LANGE:
You are right. The Aging and Disability Services Division gives us another step we can take, and the bank is another. You are right that when someone thinks they are in love with someone and they want to send them money, they will resist any effort to stop them from sending that money. That is exactly what this legislation is about. It lets us bring an outside, rational mind into the situation and insert a pause into the transaction. It is for activity that happens in bank accounts that is not normal for that person; it is something they do not do every day.

SENATOR STONE:
I applaud everything you are doing. I would further emphasize that banks need to be held more accountable when they see an elderly person coming in and wiring $60,000 to an unknown person. There needs to be more than just asking, "Do you know this person?" Maybe we need some tightening of regulations that ensures that a senior citizen must include an emergency contact when they open a bank account. That contact could then be called and asked, "Are you aware that Mr. C wants to wire $100,000 to Mrs. X in Ghana?"

SENATOR HAMMOND:
It is always interesting when you bring two such disparate groups together. As Senator Lange mentioned, we have been doing this for about a year and a half with the Aging and Disability Services Division and banking. It is good to get different actors in the room so they start to talk to each other.

SENATOR STONE:
I applaud you both for taking a stab at this and protecting vulnerable populations from further incursions. I look forward to voting yes on this bill.

CHAIR SPEARMAN:
I believe statute contains provisions for enhanced penalties when crimes involve older people. Mr. Fernley, can you speak to that, please?

MR. FERNLEY:
Yes, there are statutes that impose enhanced penalties for various offenses committed against persons aged 60 years and older. They would definitely apply to financial exploitation offenses.

SENATOR BUCK:
What a wonderful bill. When my son was overseas in Korea serving in the military, my father received a phone call from Jamaica from someone who said my son was in jail there and horrible things were happening to him. My father immediately went to Walmart to wire the money. The people at Walmart said, "Wait—before you do anything, you need to call your family." If my father had called me, I would have told him my son was in Korea, not Jamaica, but I think he wanted to protect me because he called my husband, who is in law enforcement. My husband told him absolutely do not wire the money, and give me the number that called you.

I love the stops this bill puts in place. I would like to see it expanded to cover all the places that let you wire money. Perhaps that could be three or four questions you have to ask or other stops in place, as well as immediate connections with law enforcement. There is probably not much that can be done in Jamaica or wherever this call came from. Such events are alarming and highly stressful even when no money changes hands. My father was convinced horrible things were happening to my son.

MR. CAIN:
The Nevada Bankers Association is in support of S.B. 355.

I would like to applaud Senators Lange and Hammond who spent an inordinate amount of time working on this important legislation during the Interim. The section we are most excited about provides financial institutions and their employees with enhanced tools to fight elder financial exploitation. Why is this so important? Adults who are 65 years and older have lost more money to fraudsters than any other age group. One in five adults in this group has been victimized, with women nearly twice as likely to be victims. They are targeted because they have money or assets, are trusting of others, often live away from family members, can have technological challenges and may be mentally or physically vulnerable.

Nevada's statutes are behind many other states in this area. The first state to allow financial institutions to pause a transaction when financial abuse was suspected was Washington in 2010. Since then, states across the Country have enacted report-and-hold laws that provide financial institutions and their employees with the tools they need to protect seniors and other vulnerable persons.

If, for example, somebody comes into the bank and says they want to transfer $10,000 to a remote location, and it is not a transaction that would be typical for them, a bank would currently have the ability to report that transaction to the Aging and Disability Services Division or local law enforcement. However, they would not have the ability to place a hold on the transaction. That is what we want to accomplish with S.B. 355.

SANDY O'LAUGHLIN (Division of Financial Institutions, Nevada Department of Business and Industry):
We are neutral on S.B. 355.

SENATOR LANGE:
Thank you for hearing this bill. It is a great opportunity to modernize the process and adapt to the evolving needs of the financial industry while ensuring safety and security of customer information. I urge the Committee to support this bill.

CHAIR SPEARMAN:
I will close the hearing on S.B. 355. Is there any public comment? Hearing none, we are adjourned at 10:16 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
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
S.B. 194	C	10	Heidi Englund	Written testimony
S.B. 194	D	12	Chair Spearman	Letters of Support
S.B. 194	E	12	Vivian Leal	Written testimony
S.B. 194	F	12	Vivian Leal	Chart of annual price trends
S.B. 352	G	21	Senator Stone	Conceptual amendment
S.B. 355	H	29	Connor Cain / Nevada Bankers Association	Proposed amendment