MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-Third Session
March 3, 2025

The Committee on Commerce and Labor was called to order by Chair Elaine H. Marzola at 1:31 p.m. on Monday, March 3, 2025, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 3 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/83rd2025.

COMMITTEE MEMBERS PRESENT:

Assemblymember Elaine H. Marzola, Chair
Assemblymember Sandra Jauregui, Vice Chair
Assemblymember Natha C. Anderson
Assemblymember Max E. Carter II
Assemblymember Lisa K. Cole
Assemblymember Melissa R. Hardy
Assemblymember Brittney M. Miller
Assemblymember Daniele Monroe-Moreno
Assemblymember PK O'Neill
Assemblymember Erica P. Roth
Assemblymember Selena Torres-Fossett
Assemblymember Steve Yeager
Assemblymember Toby Yurek

COMMITTEE MEMBERS ABSENT:

Assemblymember Heidi Kasama (excused)

GUEST LEGISLATORS PRESENT:

Assemblymember Gregory S. Koenig, Assembly District No. 38
Assemblymember David Orentlicher, Assembly District No. 20

STAFF MEMBERS PRESENT:

Marjorie Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel
Daniel Peinado, Committee Counsel
Logan B. Service, Committee Manager
Cynthia Ihejirika, Committee Secretary
George Whalen, Committee Assistant

OTHERS PRESENT:

Mariah Smith, President, Nevada State Board of Optometry
Danny Thompson, representing Nevada Optometric Association
Ken Kunke, PharmD, Executive Director, Nevada Pharmacy Alliance
Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Liz Moir, PharmD, Director, Patient Care Services, Albertsons Companies, Inc., Boise, Idaho
Adam Porath, Director at Large, Nevada Society of Health-System Pharmacists
J. David Wuest, Executive Secretary, State Board of Pharmacy
Matt Robinson, representing Southern Nevada Health District; Southern Nevada Community Health Center; and Vegas Stronger
Amy Hale, Private Citizen, Henderson, Nevada
Zach Rosko, Private Citizen, Las Vegas, Nevada
Evan Williams, Private Citizen, Henderson, Nevada
Netochi Adeolokun, PharmD, Director of Clinical Pharmacy Services, Community Health Alliance
Kelsey Maxim, PharmD, Director of Retail Pharmacy Services, Community Health Alliance
Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative
Jeani Smith, PharmD, Chief Pharmacy Officer, Nevada Health Centers
Jonathan Wolfson, Chief Legal Officer and Policy Director, Cicero Institute
Lea Cartwright, representing Nevada Psychiatric Association
Sarah Adler, representing American College of Obstetricians and Gynecologists, Nevada Section
Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association
Nehal Naik, Private Citizen, Las Vegas, Nevada
Shelly Capurro, representing Nevada Association of Health Plans
Grace Larkins, Private Citizen, Reno, Nevada
Spencer Flanders, representing Nevada Psychological Association
Laurie Drucker, Legislative Co-Chair, Nevada Psychological Association
Wesley Harper, Director of Government Affairs, City of North Las Vegas

Chair Marzola:
[Roll was called and Committee rules and protocol reviewed.] Welcome to those here in Carson City, joining us by videoconference in Las Vegas, and anyone tuning in over the Internet. Today we will be hearing three bills, Assembly Bill 183, Assembly Bill 186, and Assembly Bill 207. I will be taking those bills in order. With that, we will move to our first agenda item. I will now open the hearing on Assembly Bill 183. This measure revises provisions relating to optometry. Assemblymember Koenig, welcome to Commerce and Labor on this great Monday. You may begin when you are ready.

Assembly Bill 183: Revises provisions relating to optometry. (BDR 54-151)

Assemblymember Gregory S. Koenig, Assembly District No. 38:
Thank you, Chair Marzola, for allowing us to present Assembly Bill 183. Let me tell you a little bit about this bill in front of us today. The genesis of this is last session I carried a bill for the Nevada State Board of Optometry. The Board of Optometry consists of four members. Who makes a board with an even number? I am not sure, but it currently sits at four members. There was a part last session in the bill where two of the members were leaning one way and two of the members were leaning the other way. That left me in the middle and not sure which way to go. At that point, I approached the Board and asked if they would be amenable to add a fifth member to their Board so they would not have an even number anymore. That was the main reason for me to want to bring this forward. Since we were bringing this forward and it had to do with optometry, there is going to be some cleanup and a few little additions the Board of Optometry is recommending.

I will start with a couple of amendments right off the bat [Exhibit C]. We have decided to scratch section 4. On page 4, lines 24 through 27, there was some concern by some members of the Committee on this section. To deal with those concerns, we have decided to eliminate that section, so section 4 is completely going away. In section 5, we have replaced the words, "any analgesic or non-analgesic" with "when prescribing an opioid narcotic analgesic or non-analgesic." Talking about that a little bit more, I am not 100 percent sure that all the way meets the intent and needs. I am going to turn the time over to the president of the Board of Optometry, Mariah Smith, to maybe explain that a little bit better and also go through the other parts of this bill.

Mariah Smith, President, Nevada State Board of Optometry:
I will go in order of the different sections, and I will try to be brief. We will go over section 5 as well. Sections 2, 3, and 11 are ways for the Board to be able to enforce our laws and have licensees comply. Section 4, as Dr. Koenig noted, is gone. With section 5, the goal of changing it was to clarify what medications optometrists can prescribe and in what context. I think we can collaborate on that with Dr. Koenig to get that language a little bit easier to digest and clearer. We are not really changing anything. We are trying to clarify laws that were already in place. The rest of this is a bunch of cleanup.

Sections 6 and 7, as Dr. Koenig mentioned, is adding a fourth [*sic*] Optometry member to create a tiebreaker. In section 8, there are different countries with different national boards they have to take, and we are trying to clarify in America and in Nevada, it has to be our national board the licensees are taking to get licensed here. In section 9, the 40 hours of clinical training for pharmaceuticals is already incorporated in the optometry school curriculums that they are getting that training, so there is not a need anymore for our optometrists to get 40 hours under an ophthalmologist to be able to prescribe pharmaceuticals.

In section 10, we had that an optometrist had to be endorsed by a Nevada ophthalmologist to get glaucoma by endorsement, but there are lots of good optometrists who would like to move to Nevada who have been working in a medical practice with an ophthalmologist in lots of different states, that ophthalmologists could, and should, be able to sign off on their ability to treat glaucoma. In section 11, I already mentioned it is allowing us to be able to enforce our laws with our licensees. Sections 12 and 13 are clarifying that our laws also go to teleoptometry, not just optometry, but teleoptometry or telemedicine.

In section 14, there are two different categories of penalties. There are administrative ones and there are ones that affect the public safety. If there is an administrative thing, such as I filed my paperwork late or I did not send in my check, those are not things that are going to be reported to the National Practitioner Data Bank that I was penalized for something. In section 15, we made a law a couple of years ago because we had an optometrist die suddenly and we needed to know how his family was able to pass along his optometry office when we say that an optometry office needs to be owned by an optometrist. We wanted to extend that a little bit further to an optometrist who was permanently incapacitated. They should also have a route on how quickly they need to pass their optometry office into somebody else's hands. Section 16 allows for citations and administrative fines when they are not harming the public. We would like to open it for any questions.

Chair Marzola:
Are there any questions?

Assemblymember Miller:
I have a brief question under section 8. I believe it is section 8 when you mentioned about those who had successfully finished the exam from the National Board and stating that it had to be through the United States or Nevada. When it comes to those professionals coming from other countries, is there reciprocity, or what is the process for them?

Mariah Smith:
That is something that was brought up a couple of years ago, and I think that would be a great thing to move forward to in the future. I do not think we figured out what is on those tests, what those laws look like, or what kind of optometrists would be coming from other countries. I think the training programs are really different in different countries. I know in Australia, you can be straight out of high school and go be an optometrist, where in the United States, you have to go to an undergraduate program, whether that is a two-year or

four-year program. It used to be four years. I think there are a lot doing two years now. It is different, so we would need to look and see with each country what their standards are before we can go down there. I think that would be a great thing to move forward to in the future.

Assemblymember Miller:
Is there the ability now for a practitioner from another country to take that exam, or is it the process of you identifying what undergraduate or graduate courses they have taken and then they could take the exam? Again, especially in the medical field, we are trying to get more professionals working.

Mariah Smith:
That is a little bit out of our control because it is really the national boards that are doing that, and we just accept the tests from the people who have passed the national boards. Again, I believe this is an initiative that is not just new to Nevada or new today. It has been in the talks for a couple of years. I think everybody recognizes there could be great practitioners from other countries. The way the Nevada law currently is, they need to pass the National Board of Examination in Optometry, the national boards that are provided in the United States. I believe they could pass that test from another country even without the undergraduate stuff, but that is a little bit outside of what we are in charge of.

Assemblymember Cole:
My question is on section 3, when we talk about the Board reasonably determining from an investigation of a licensee that health, safety, or welfare is at risk, and then going into the process of there being an up to 60-day suspension until a hearing happens. I did a tiny little dive into how the State Contractors' Board handles things, and they specify some time frames in which the complaint comes in and the time frame in which the investigation happens. I think that might be a good add-in here to give the person some clarity.

Mariah Smith:
Thank you for the suggestion. We will work with Dr. Koenig and see if there is a way to make that work out.

Assemblymember Koenig:
I heard what you said, but I did not all the way understand what you said. What was your recommendation?

Assemblymember Cole:
If you look at how the Contractors' Board works, there is a time frame by which the complaint comes in and then it is within, I believe 10 days, maybe 10 business days, that an investigation has to be done. That verifies, so the person understands whether there is an issue. You have the 60 days before the hearing happens, and 60 days is a long time for someone to wait.

Assemblymember Koenig:
I think that is definitely something we can consider and put in as an amendment before we get a work session.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] A couple things, thank you for the proposed amendment [Exhibit C], especially on section 4, which was the one I had a huge issue with. I appreciate the removal of that. I have a question on sections 12 and 13, where it states optometric telemedicine. In those sections for the telemedicine, is there a preexisting relationship between the doctor and the patient?

Assemblymember Koenig:
I will answer this one; if she needs to correct me, we will go to her. That was one of the biggest parts of the bill I brought last time. It was to implement and define telemedicine because for the rurals where I live, it can make a big difference. I give the example of giving someone a pair of contacts. They have to come to my office and see that, and then typically I make them come back the next week to make sure they work before I give them the final prescription. I have patients routinely who come from three hours away, if not more than that. If everything is working just fine, that is a five-minute appointment. To make them drive three hours each way for a five-minute appointment for me to say, Yes, they are working; they are fine. That is one of those things we can do telemedically.

Yes, they have to be an established patient with me and then those follow-up types of visits we can do telemedically. It is not, I have never seen you before, you are on my computer screen, here is a pair of glasses, we will catch you next time. That is not how telemedicine is working.

Chair Marzola:
Thank you for that response. Of course, I was here for that bill last session, and I know you worked a lot on it. I wanted to get that on the record as well. Last chance, Committee members, are there any questions? [There were none.] We will hear testimony in support of A.B. 183. Is there anyone here wishing to testify?

Danny Thompson, representing Nevada Optometric Association:
We represent over 200 optometrists statewide. This bill is important. This Board has done a good job overseeing optometrists in Nevada. As you can well imagine, a board with an even number of members creates situations that are pretty hard to deal with. I think the most important part of this bill for us is that. We urge you to support.

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to A.B. 183. Is there anyone wishing to testify in opposition? [There was no one.] We will move to testimony in neutral. Is there anyone wishing to testify in neutral? [There was no one.] Assemblymember Koenig, would you like to give any final

remarks? [There were none.] I will close the hearing on A.B. 183. I will now open the hearing on Assembly Bill 186. This measure revises provisions governing pharmacists. Assemblymember Orentlicher, welcome. You may begin when you are ready.

Assembly Bill 186: Revises provisions governing pharmacists. (BDR 54-344)

Assemblymember David Orentlicher, Assembly District No. 20:
Thank you for the opportunity to present Assembly Bill 186. I am joined by some copresenters who are on Zoom and here. The bill responds to a concern we have heard much about, the shortage of doctors and other health care professionals in Nevada. We need thousands more doctors, thousands more nurses, and thousands more other practitioners to reach the national average. With such a serious shortage, it is essential Nevadans receive the full benefits our existing health care workforce can provide. We need to ensure our health care professionals can practice to the full extent of their expertise and skill set.

Unfortunately, that is not always the case. One area in which we unduly limit what health care professionals can do is pharmacy services. The expertise and skill set of pharmacists goes well beyond what our laws allow them to do. This bill is designed to allow Nevadans to benefit more fully from the expertise and skills that our state's pharmacists possess by expanding the kinds of services pharmacists can provide.

Fortunately, we do not need to venture into uncharted territory. As my copresenters will share, similar legislation has been successful in Colorado and Montana, and more expansive legislation has been successful in Idaho and Iowa. I will now turn to Ken Kunke, the Executive Director of the Nevada Pharmacy Alliance, to go through the background of the bill. He suggested this bill, and I believe he is with us on Zoom.

Ken Kunke, PharmD, Executive Director, Nevada Pharmacy Alliance:
I am a practicing pharmacist here in Nevada, and I have been here since 2003. The first slide I have here on A.B. 186 is two terms I wanted to make sure that the whole Committee was aware of [page 2, Exhibit D]. The first one is called a Clinical Laboratory Improvement Amendments (CLIA)-waived test. The CLIA-waived tests are those tests that are determined by the Centers for Disease Control and Prevention or the U.S. Food and Drug Administration (FDA) to be so simple there is little risk of error. Think of a pregnancy test. When you take one of those, it says yes or no, or a positive or negative. Those are the kinds of tests we are talking about when we talk about CLIA-waived tests, and it does not include blood draws or something more invasive.

The next thing is called standard of care. All health care professionals have to abide by this, and I pulled a definition off of the Internet. The first thing about standard of care is you are not providing any clinical services that are prohibited by state or federal law. The next thing is you are only providing services that are within the individual's education, training, or experience. The third thing is performance of the act is with an accepted standard of care that

would be provided in a similar setting by a reasonable and prudent individual with similar education, training, and experience. If you are getting called in front of the Board, you would have to prove those things on why you did that service.

The next thing, and Assemblymember Orentlicher did submit this [page 3, Exhibit D], there are a couple of amendments we are proposing [Exhibit E]. The first one is on page 4 [Exhibit D], section 1 [*sic*], and it changes "have been previously diagnosed" to "do not require a new diagnosis." On this, a pharmacist would be able to prescribe medications and devices based on some things that were left out of the first definition, including epinephrine for allergies; immunizations, which we already can do under protocol but it would put this in statute; and contraceptives. Once again, we could do that under statute. We can dispense contraceptives without a prescription, but this would make the law clearer. In the second amendment, we can also do a lot of things with lab work. When we sit down to assess a patient, we are always looking to see what ranges they are in and if their medicines need to be increased, decreased, or discontinued. Right now in our law, it does not say we can interpret that lab work, so we are asking to put that in [page 5].

The substantial changes in this bill in section 1, we would be able to prescribe for conditions that do not require a new diagnosis [page 4]. Right now, pharmacists are not being taught on how to diagnose patients in school, so we are going to leave that up to the physicians, the nurse practitioners, and the physician assistants. In a lot of situations where a pharmacist is working inside of a medical clinic, they may be sitting down with that patient in three months or six months and going over all the patient information, such as what they were diagnosed with, their medications, and their lab work. They are coming up with a plan and referring them out to other providers. Right now, we cannot make changes to those actual medications, such as their dosage or changing the medication. That is what this would do.

In the next one, we would be able to prescribe for conditions that are self-limiting [page 4]. Right now, we do a lot of recommendations, assessing and recommendations, of over-the-counter medications, but there are some conditions that actually need a prescription to get better. A case like this would be pink eye where an antibiotic eye drop would be required to prescribe. Things like that we would be able to prescribe for.

Next, we could prescribe for conditions that are diagnosed after performing a CLIA-waived test [page 4]. We have been doing this since the beginning of the COVID-19 pandemic. The Public Readiness and Emergency Preparedness Act (PREP Act) by Congress allows us to actually do COVID-19 tests, and if that is positive, prescribe medications for COVID-19. The PREP Act will be expiring, and we want to make sure we are able to keep continuing to do those CLIA-waived tests and getting patients the care they need. Also in this section, it would expand that to things such as strep throat, flu, or other things CLIA-waived tests are available for.

In the professional judgment of a pharmacist are emergencies that threaten the health of the patient [page 4, Exhibit D]. Once again, we were able to prescribe for emergencies throughout the pandemic by an order that was given by the Board of Pharmacy that has now

expired. A situation like this would be if a patient came into town, forgot their medications, and we were not able to get a hold of their provider, but they had proof of what they were on. We would be able to prescribe those medications to get them through until they got home to get their medicines they left back home.

The good news is that inside A.B. 186 there are a lot of guardrails built in to make sure pharmacists are actually doing the right things. The first one is that we could only prescribe drugs or devices that are approved by the FDA. It also gives the Board of Pharmacy the ability to adopt regulations to make sure the things such as what training the pharmacist would have to do or if there are any protocols that need to be made—the Board of Pharmacy is there to protect the patients in our state, so they would be making those regulations before we could do this.

In section 2, it adds a couple of things to the practice of pharmacy [page 5]. Right now, we are able to administer drugs in a lot of situations, such as when a provider prescribes something on a prescription. We are able to take that prescription, and if the drug needs to be administered, we are able to do that. In the 2021 Session, there was a statute that passed that said pharmacists could dispense hormonal contraceptives without a prescription. Unfortunately, in that case, we cannot administer those drugs if needed. This would include that. Also, we talked about how we are able to do a lot of different things with lab work. Right now, we are able to actually perform laboratory tests for blood glucose, give the patient their readings, and refer them out. We want to make sure we can also order and interpret for those tests. The last point is just going back to section 1.

Section 5 has to do with lab work also. As I mentioned, pharmacists sit down with patients, assess them, and go over lab work. But right now, we are not able to order that lab work. If a pharmacist is working in a clinic, it is important they can put orders out there to be able to take care of that patient and then interpret that. Section 5, subsection 1, paragraph (b) is that we would be able to perform those CLIA-waived tests inside those pharmacies.

Section 7 would allow us to serve as the laboratory director of an exempt laboratory [page 6, Exhibit D]. The only reason why we are adding this in is because to do CLIA-waived tests inside of a pharmacy, a pharmacist has to register as a laboratory director of an exempt laboratory in order to do those CLIA-waived tests.

We heard earlier today that Nevada has a shortage of primary care professionals. Right now, we rank 48 out of 50, and all 17 of our counties have a whole or partial shortage [page 7]. We do have over 2,700 pharmacists licensed here and living in Nevada. Since 2004, all pharmacists that graduate pharmacy school have to get their Doctor of Pharmacy degree in order to practice. That includes 6 to 8 years of education; at least 1,740 hours of clinical training in direct patient care where it is working directly with patients; then we take our boards to make sure we are competent to practice as a pharmacist; and about 30 percent of pharmacists go onto additional training, such as residencies, fellowships, or board certifications and specialize in different areas.

You are probably thinking, How does pharmacy differ from other medical professionals? Pharmacists use evidence-based medication and clinical guidelines, just like doctors, nurses, physician assistants, and nurse practitioners [page 8]. We are going to be doing the same type of things when we are assessing the patients as they would. Also, when we are working inside clinics, hospitals, or pharmacies, we are gaining experience depending on what we are doing. We will also be billing insurance companies for the clinical services. We will have to make sure we are contracting, credentialing, and getting audited by insurance companies. That is another guardrail to make sure we are doing good things.

What we have seen in other states is that even those statutes have guardrails, and the boards of pharmacy have guardrails, the individual companies are also making protocols, and they are determining what types of training the pharmacist would need, and what they need to do for those clinical services. Like I said, we must provide standard of care. We have to make sure we are doing things that are best for the patients. All this includes collaboration with other health care professionals, including documentation of those services and referrals when needed.

We keep hearing it is unsafe, but if you do a search, we cannot find any studies or reports that say pharmacists doing these types of services are unsafe. What we do find are a lot of studies that say the opposite. Right here [page 9, Exhibit D], we are highlighting a meta-analysis that looks at 298 different studies that says using pharmacists as part of a health care team is a viable solution to improve U.S. health care. Also, there are studies out there that say when a pharmacist is part of that team, they do save the health system money. That could include making sure the patients are taking their medications right and making sure they are in the correct lab values, and that can reduce emergency room visits or other health care visits.

Right now in Nevada, we can do a lot of different things either through laws that have passed or federal laws that have passed. The first one is medication therapy management [page 10]. That is like sitting down with that patient and going over their whole background and making that plan and referring them out. In the last two sessions, you have also given us the ability to dispense those hormonal contraceptives without a prescription, assess patients and prescribe medications for human immunodeficiency virus (HIV) prevention, and assess patients and provide medications for opioid use disorder.

Unfortunately, there are some red boxes down here that A.B. 186 would help with [page 10]. Right now, we cannot prescribe the drug. The pharmacists who work inside of the dispensing pharmacy can actually dispense the hormonal contraceptives without a prescription, but a pharmacist who works inside of a clinic or in a hospital, they cannot prescribe a hormonal contraceptive. It is a little glitch in the law. The next one is for HIV prevention. We cannot serve as a CLIA-waived lab director. It is happening throughout the states. Basically, we are overriding the law with the PREP Act, so we need to get that fixed. For opioid use disorder, we cannot order urine drug screens. The asking of patients to urinate in a cup, according to

our current law, we are not allowed to do that, but this law would fix that because it is part of standard of care and the guidelines. There are two other ones, but for time, I am not going to talk about right now, but I will answer questions on if necessary.

We talked about how these services are being done, and they are safe [page 11, Exhibit D]. Since the 1960s, the clinical services have been done inside hospitals through protocols. In the early 2000s, the federal practice sites allowed pharmacists to do these types of things through the Veterans Affairs (VA) health system and Indian Health Services. If you are wondering how many states have the authority for pharmacists to test and treat using CLIA-waived tests, right now there are 16 states that allow that. These states have almost all come about since the beginning of the COVID-19 pandemic because they saw that it was safe, and when the PREP Act expires, they will still be able to do it. As Assemblymember Orentlicher said, those are Colorado, Idaho, Iowa, and Montana. They have the ability to do all the things we are asking. Idaho and Iowa have more things than we are asking.

I do have the references [pages 12 and 13]. As you can see, this is being done throughout the United States and Nevada already. There are some statutes we need to fix, and we want to make sure when the PREP Act expires we are able to continue doing this to take care of our patients. I will pass it back to Assemblymember Orentlicher.

Assemblymember Orentlicher:
We have more experts, Liz Moir from Albertsons, and Liz MacMenamin, but how are we doing on time for our presentation?

Chair Marzola:
Are they presenting or just answering questions?

Assemblymember Orentlicher:
I think each of them might have wanted to speak for a minute or two and then answer questions as well.

Chair Marzola:
A minute or two is fine.

Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
We believe at the Retail Association that these test and treat problems we have had, as many of you that have seen me before know, I have been working on this for many years now to bring Nevada up-to-date and to fill a much-needed void in our health care community. I would hope people would be open to the changes, and going forward, we hope this Committee can see the importance of this.

A recent poll showed that 78 percent of the adults in Nevada believe it is important for the state to update its policies to ensure patients permanently have the same access to pharmacy vaccinations, testing, and treatment services that were available during COVID-19.

Eighty-six percent of the adults in Nevada say pharmacists are easy to access, and I want to emphasize it is an easy and safe access for patients when they cannot get in to see their doctor for the simple tests and to have these done within the community pharmacy.

We have been working on this for a long time, and I ask that you consider this. We urge your support on this so those patients can receive the health care they need. I thank you for your time.

Liz Moir, PharmD, Director, Patient Care Services, Albertsons Companies, Inc., Boise, Idaho:

I would also like to note I am a pharmacist practicing in the state of Idaho. Thank you for the opportunity to testify today in support of A.B. 186. This bill will increase patient access to timely pharmacist treatment while maintaining high safety standards. Albertsons Companies has 37 locations in the state of Nevada, operating under banners of Albertsons, Safeway, Sav-on, and Vons. Nationwide, we have 1,726 pharmacies across 34 states and the District of Columbia. Our pharmacies provide critical support in Nevada's health care infrastructure, and in some cases are the only available access to a pharmacy in rural communities.

Albertsons has successfully and safely implemented pharmacists prescribing across the country with our pharmacists issuing over a million prescriptions annually across many drug categories and disease states, while maintaining the highest standards of patient safety. Our real-world experience has shown pharmacists are the critical first point of access for countless patients, many of whom do not have established primary care providers. Pharmacists prescribing has enhanced patient care, ensuring individuals receive timely treatment for minor and chronic conditions. Our pharmacy locations serve as key referral hubs, directing patients with more complex medical needs to appropriate health care providers. Our approach strengthens the patient-centered medical home model.

As a mother, my family's health is my top priority, and timely access to care can mean the difference between a manageable illness and a medical crisis. Long wait times at primary care offices, urgent care, and emergency rooms often leave us struggling to get the care we need when we need it most. Allowing pharmacists to prescribe medications for common conditions would provide a safe, convenient, and immediate solution for families like mine. For busy parents juggling work, school, and family responsibilities, a pharmacy visit could mean getting a sick child the right medicine in minutes instead of hours or even days. Allowing pharmacists to prescribe for common ailments is not just a matter of convenience. It is a lifeline for families who need timely, affordable, and expert care.

Assembly Bill 186 follows the success of Idaho, Colorado, Montana, and Iowa. This meaningful legislation will increase patient access to timely treatment while maintaining high safety standards, providing a strong precedent for Nevada to follow. Thanks for the opportunity to speak today.

Adam Porath, Director at Large, Nevada Society of Health-System Pharmacists:
We are the organization that advocates for pharmacists and pharmacy technicians working in hospitals and health systems within the state. I have been a practicing pharmacist in Nevada since 2006. I have been working in direct patient care in a collaborative practice agreement in a clinic at Renown Health in Reno since about 2009. A lot of my testimony has already been gone over. I want to highlight that a lot of progress has been made in the time I have been practicing in the state. Fast forward to today, pharmacists can, through a collaborative practice agreement, see a patient in an office setting and help manage their chronic disease states like diabetes and high blood pressure. Today, we can independently prescribe medications to prevent HIV, treat opioid use disorder, and furnish oral contraceptives. I think A.B. 186 builds on those past successes of increased utilization of pharmacists and takes advantage of their place in the community as the most successful health care provider.

The other thing that has not been touched on a lot is that this bill modernizes the language of the Pharmacy Practice Act to allow the Board of Pharmacy to establish the scope of this independent authority and establish that standard of care for pharmacist services in our state. This particular language will allow the practice of pharmacy to evolve with evolving advances of medical science and practice.

I want to thank Assemblymember Orentlicher for his forethought in introducing this bill, as I think it will truly help to advance and expand access to health care in our state. I am happy to answer any questions you might have.

Chair Marzola:
Committee members, are there any questions?

Assemblymember Miller:
I am trying to get a full understanding of what the scope would be. There has been some conversation about how it would not be about making a diagnosis. It would be for things that were more, I do not want to say chronic, but maybe consistent. My pause is, of course, the pharmacists as skilled and trained as they are, they do not know each individual's medical history, family history, vitals, and all those sorts of things. I know for myself, even when I was seven years old and going through a lot of ear, nose, and throat issues, I would go to my parents and say, I need some amoxicillin. I knew that was what I needed. Is it for the scope of those types of things, even if it is not your consistent blood pressure, cholesterol medication, or something like that? Even medications like amoxicillin, you need penicillin for a specific condition, and many parents and kids can kind of self-diagnose, and this is what is going on, and my kid needs amoxicillin. Would that be an example of what we are trying to achieve here? I will pause there and leave it there. Is that within the scope of what this bill is trying to achieve?

Assemblymember Orentlicher:
Yes, this is for people who have already been diagnosed. The language says, "does not need a new diagnosis." It is self-limiting, a minor condition, or an emergency. Maybe you have run out of your prescription and it is the weekend, and your doctor's office will not answer the phone.

You are going to hear from the opposition, Well, cholesterol tests are one of those CLIA-waived tests. This bill does not mean you come in and we diagnose you with high cholesterol. They are not going to start managing you chronically for coronary artery disease. That is not what this bill does. One of the reasons why that is not going to happen is the section that says the Board of Pharmacy is going to implement regulations to flesh this out. If we just went by what is in the statute, I am a licensed doctor. I can do anything with my license. I could do brain surgery with my license, but we do not use the statutes to go into the kind of detail because there are other regulatory mechanisms to make sure David Orentlicher is not doing brain surgery tomorrow.

Assemblymember Miller:
That last statement made me feel a lot more comfortable as well. Thank you for that.

Assemblymember Jauregui:
Can you give us an example of a time when a pharmacist can reissue a prescription without issuing a new diagnosis? Give us one example.

Assemblymember Orentlicher:
Mr. Kunke, do you want to step in?

Ken Kunke:
It looks like Ms. Moir is going to, as she is the one who does it on a regular basis. I will let her.

Liz Moir:
I have a few examples of how we do this. We offer 29 different services in the state of Idaho. Think about things like cold sores. That is one of the first ones we started with in 2018. Somebody that has had a cold sore in the past, but they do not have a current prescription for it. They come in; they know they have a cold sore; they have been diagnosed in the past, but maybe it has been five years, and their medication is expired. We do a very thorough screening for that. We get their medical history, and any medications they have been on. Our pharmacists have additional training on what a cold sore looks like. What are the differential prospects? We do not need as much because that person knows they have had cold sores in the past. That is one good example where they may need an oral antiviral to treat that is not available over the counter, or they may need a topical antiviral. That is one we look at.

There is another one: urinary tract infections (UTI), which we do in Idaho. If you look at the guidelines, the guidelines say most women, if you have had one before, you know what it feels like. We do any lab work that needs to be done, blood pressure, or any of that. It is the

same as if you are going into a physician's office. There could be a urinalysis if you need one that they do in the restroom. There are a lot of different things that can be done to help provide that care we are looking at. It is minor and self-limiting in nature that does not require a new diagnosis. Does that help answer the question?

Assemblymember Jauregui:
Yes, it did. I wanted to put on the record the kinds of examples of how a family would be able to use this. I like that a family might not have to take time off during the day and pull a child out of school to go see their doctor and wait there for hours to get a new prescription for a cold sore. They could do it after they get out of work at 5 p.m. I like that, especially increasing the access to families throughout Nevada because we do have a problem with access to health care here in Nevada.

I do want to ask, what is the capacity of pharmacists in Nevada to be able to handle this? If this bill passes, do we have enough pharmacists in Nevada to handle these requests that would be coming into their offices every day? Would that increased workload hurt them in any way?

Ken Kunke:
When these laws pass, it is a slow burn as how they roll out. We saw in Ohio when they were able to start billing for clinical services, only about 0.5 percent of pharmacists billed for clinical services the first year they rolled out. In the second year, it was 1 percent of those pharmacists. Each company is going to have to determine their capacity to be able to do these services, such as Albertsons, CVS, and those types of things. We do see them rolling out slower rather than faster because they want to make sure it is safe and everybody is trained.

Assemblymember Jauregui:
I did not see that in the language, and maybe you could point me in the right direction if I overlooked it. I saw the Board may adopt regulations. I did not see the Board would be required to adopt regulations for this. If this bill passes, would pharmacists automatically be able to start practicing in this way? Would there be a requirement for the Board to come up with regulations? Could you walk us through a timeline to implementation? If this bill passes, what is that timeline to implementation?

J. David Wuest, Executive Secretary, State Board of Pharmacy:
I am neutral on the bill, but I was asked to be here for questions. "May" was my request because with "shall," if there was no opportunity to do anything, then I have to do regulations when there is nothing to do. I think the Board would be doing regulations. We have done that through everything else you have given us they have already mentioned, all the categories where pharmacists can dispense and prescribe. I think we will. I think there are some low-hanging fruits, so we are listening to you on what would be the first things we would tackle. I think there are patients who would want to go to the pharmacy and be able to get a prescription at that time. To your point, they are getting the questions now, but they cannot do anything about it.

Assemblymember Jauregui:
With the last part of my question, the timeline to implementation. If this bill passes, when would it happen?

David Wuest:
Six months would be a typical time frame if everything goes. Again, I point out that nothing would move forward without the Legislative Commission on regulations approving it. It is not like the Board would do it and then the Legislature would lose control of what is happening.

Assemblymember Hardy:
I think most of us have had those late nights and things where you go to the pharmacy for a child or ourselves and ask, I am not feeling well. Can you recommend something for me? I understand that, and I am getting a better grasp of what the CLIA-waived tests are and what they could prescribe for self-limiting conditions and things like that. What if they come in with a certain condition that worsens? You could have a symptom that maybe you think is a cold or flu, but it is actually indicative of something more. I am especially thinking for children or older people. Is there any requirement or did they do this already? Do they need to contact a physician if it is getting worse or there are more symptoms developing?

Adam Porath:
Yes, I think that goes back to what is the standard of care. If you are going to be testing for strep throat, and you are going to be providing treatment for that, if there is an indication that it is beyond the scope and that needs to be referred to a higher level of care, that is absolutely within this. You are not going to be able to do that simply with this CLIA-waived test. You would have to be able to take a blood pressure and see what is going on there. If there are indications this is something that is worsening or an infection that maybe cannot be treated in an outpatient setting, that would be part of the process where the pharmacist would need to refer a patient.

Assemblymember Cole:
When we are talking about the professional judgment of the pharmacist or emergencies that threaten the health of the patient, Assemblymember Orentlicher, you gave an example of something that seems to make a lot of sense. Somebody is on vacation; they forgot their meds; and they get a prescription. I think this language needs to be tightened up significantly. I think what could also fall into that is somebody in a mental health crisis moment, and I would not want pharmacists to be able to prescribe some kind of drug like thorazine, stelazine, or something that would be very strong. I think that language needs to be tightened up.

Assemblymember Orentlicher:
I would be happy to work with you on getting the language right.

Assemblymember Cole:
Thank you very much. You probably will not have this information with you. I look at it from the perspective of whatever malpractice insurance these pharmacists have to carry now, and what the implication could be for their malpractice premiums to go up significantly because the scope of practice is being expanded so much. Perhaps from the other states, you might have that information.

David Wuest:
There are other components in the law that require certain malpractice insurance when they are doing certain things. That is something that could be layered into the regulations. I think the vast majority of pharmacists do carry malpractice insurance, but to your point, it is much different than what a physician is carrying. I think your point is right. Any practitioners, and we have seen this with all the different prescribing practitioners—we had three last session that gained prescribing rights—that is obviously something they should be aware of.

Assemblymember Monroe-Moreno:
I think my question is going to be for Ms. Moir. You are in Idaho, correct?

Liz Moir:
Yes.

Assemblymember Monroe-Moreno:
How is this working with the insurance companies in your state? When the client comes in for the diagnosis, is that considered a clinical visit on the insurance or urgent care visit? How is that billing working for that visit to get the diagnosis for the prescription?

Liz Moir:
Billing is a challenge. Medical billing is finally starting to take off. In the state of Idaho, we have been recognized by our [unintelligible] as providers, so we are able to bill for a certain level of care. Depending on the service, we might do a pulse oximeter, a blood pressure, or we might do all of them. It is basically a new patient visit and potentially an existing patient visit. We have coding that is associated with the visit types. We can also bill separately for the test itself. If I do a visit for a new patient for strep then I bill a separate claim for the patient for that strep test.

Primarily, and we see this mostly across all our states that do different types of prescribing, much of it is a cash-paid business. We have a cash fee, a fee-for-service scale we do for people who are not insured. For example, if you came to Idaho, did not have any insurance, and you wanted to be seen for a UTI, you would pay $35 for the visit and then the price of the prescription. It is not quite in line with what would be the standard of care for the level of care we are providing, but the goal is to expand access to health care and make it affordable.

Assemblymember Monroe-Moreno:
For those who do utilize their insurance, is it considered an in-network charge or an out-of-network charge for the patient?

Liz Moir:
We are contracted with them in Idaho, so it is in-network.

Assemblymember Torres-Fossett:
I am definitely interested by this idea. I am wondering what procedures would be put in place or what procedures are put in place in other states to prevent individuals from . . . . I see a lot of situations in which the doctor says, Okay, you need to stop taking this medication. This person likes taking that medication. They do not want to switch for whatever reason, so they will see a different provider. I have a little bit of concern. I will be honest, there are prescriptions that are given over the counter. When I go in to get my Sudafed, it is very quick. They scan my ID, and they give it to me. What does this quality of care look like for the patient? For example, if somebody has a UTI, and they have had a UTI for a while, they should not just be coming into the pharmacy, getting the medication, coming back in two weeks, and getting the medication again. There is something else going on. How would that be addressed?

David Wuest:
How it is currently done, to your point with the Sudafed, there is a system in the background that is checking all the Sudafed, so we know if you go to multiple pharmacies for the Sudafed. As it relates to those prescriptions, I think that is under the professionalism of a pharmacist. As Mr. Porath was saying, if it is escalating or not resolving, there is going to be a referral out to a doctor or it goes to your doctor. As it relates to the pharmacist and their intention between dispensing and prescribing, we already have over 1,000 practitioners in the state who dispense along with prescribing. I think it is safe. When you bring the drugs as close to the patients as you can, that is for the best. I think the pharmacist would use their judgment. I think it is a valid point. That same patient could do that currently. Not so much with opioids because we have addressed those things. With the dangerous drugs, they could go to multiple places.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] I have a question about capacity, which you answered. I know you are wanting authority to prescribe, but we are not in any way talking about any sort of controlled substance or any sort of opioids, correct?

David Wuest:
As it states, this would not prohibit it. That might be something that Assemblymember Orentlicher could work on to resolve. That said, pharmacists currently can prescribe, and we are working through the Drug Enforcement Administration with the final level of that, to treat opioid disorder. There are pharmacists who would be able to prescribe opioids in those circumstances, but a limited amount for the treatment of opioid disorder, not for pain and those kinds of things.

Chair Marzola:
Correct. That was my question. I know they can prescribe right now for the disorder itself. What about when we are talking about painkillers and things like that?

David Wuest:
That may be something we have to do with an amendment if they choose to do that because emergencies and pain may go together. That might be something you would want to limit with the bill.

Chair Marzola:
Does anyone else want to answer my question? Is that what you are asking for in this bill, to be able to prescribe a controlled substance, opioids, and things like that as well?

Ken Kunke:
Yes, in those four states we mentioned, controlled substances are allowed. The reason why is because pharmacists do additional trainings. A pharmacist who is working in a clinic that needs to prescribe pain medications, in certain reasons they would be allowed to, but they still have to practice standard of care and would have to do everything another provider would have to do before prescribing those controlled substances.

Chair Marzola:
Thank you for that response, and we can chat more offline. My last question is on your PowerPoint when you talk about travel medication. I believe it is on page 3 [Exhibit D]. Can you give me some examples of what you mean by travel medications?

Adam Porath:
There are a lot of pharmacies that offer travel vaccines currently. In addition to that, oftentimes, depending on where you are going, you might want to have a prophylactic prescription, an antibiotic prescription for diarrhea. This would allow the pharmacist to be able to prescribe those prophylactic antibiotics.

Chair Marzola:
Great. Last chance, Committee members, are there any other questions? [There were none.] I will move to testimony in support of A.B. 186. Is there anyone wishing to testify in support?

Matt Robinson, representing Southern Nevada Health District; and Southern Nevada Community Health Center:
As a federally qualified health center (FQHC), we provide primary health care services to underserved Nevadans in our community. Pharmacists are a key part of the health care team and support services that create access to care. We encourage the Committee to support A.B. 186 to enhance the scope of practice of pharmacists to supplement the practice of other providers and increase access to essential medical care for Nevadans.

It supports our health center in three key ways: expands access to care, removes barriers to accessing essential medications, and supports the practice of other providers in the community. Once again, we urge the Committee to support A.B. 186, which will further enhance our ability to provide care for the most vulnerable Nevadans.

Amy Hale, Private Citizen, Henderson, Nevada:
I am a licensed pharmacist in the state of Nevada, and I support this bill. I am also licensed as a registered nurse in Nevada and started my health care career as an emergency medical technician 19 years ago. I have always served in a direct patient care role until 2022. I am board-certified and residency-trained but became frustrated at the continued barriers to care as I, a pharmacist, encountered, despite the fact I had 97 percent of my recommendations accepted by the nine physicians I worked with in their oncology practice in Las Vegas over the three-year period I was there.

Please remember a large number of us do not work in a typical retail pharmacy setting. I left that position for the pharmaceutical industry and my story is not unique. I know literally a dozen other pharmacists who are trying to or have replicated this path for these exact reasons. I urge you to consider passage of this bill to keep our qualified, dedicated pharmacists in direct patient care here in Nevada for better outcomes and higher quality and less expensive care for our residents.

Zach Rosko, Private Citizen, Las Vegas, Nevada:
I am a licensed pharmacist in Las Vegas and have been here since 2022. I wanted to encourage you to support A.B. 186 for all the reasons that have been stated by other presenters today. I also wanted to add that I am also licensed and have practiced in Idaho, another state with a more expansive scope than we are asking for here today. I wanted to say that I have directly seen the impact this can make on both care team-based delivery and partnering with other providers and in our patients' lives.

Evan Williams, Private Citizen, Henderson, Nevada:
I am a pharmacist in Henderson, Nevada. I have been a pharmacist in Nevada since 2016. I want to say I urge the Committee to support this bill. I have been practicing for quite a while. I am residency-trained, board-certified, and I have practiced under a much more expanded scope within the federal system as a commissioned officer at the VA and with Indian Health Services as well. I have seen firsthand the impact this type of scope extension can have. By not limiting pharmacists to what people might think is a more traditional role, we have definitely expanded access to care in all of these settings. I see a great opportunity here to try to expand this further for the people of Nevada. So again, I urge the Committee members to support this bill.

Netochi Adeolokun, PharmD, Director of Clinical Pharmacy Services, Community Health Alliance:
I am a pharmacist in Reno, Nevada. I work at a FQHC and work collaboratively with all of our medical providers who utilize the skill set of a pharmacist. I encourage everyone to support A.B. 186 to expand the services and open up more care for our patients in Nevada. [Submitted testimony in support, Exhibit F.]

Kelsey Maxim, PharmD, Director of Retail Pharmacy Services, Community Health Alliance:
I am a licensed pharmacist in Nevada. I urge the Committee to support A.B. 186 to expand pharmacists' scope of practice. As previously discussed today, I fully agree this bill will expand access to health care, improve patient outcomes, and many other direct benefits to our patients. I appreciate your time.

Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative:
Our mission priority is access to care. Here are my five takeaways of why A.B. 186 will benefit Nevada patients: (1) Many Nevadans face access to care barriers. Under A.B. 186, we heard that pharmacists could prescribe medications for minor conditions and do simple lab tests; (2) pharmacists are highly trained health care professionals that right now are underutilized. They can help with our shortages in primary care providers; (3) pharmacists are medication experts who can provide ongoing chronic conditions care resulting in better medication adherence that improves long-term health management; (4) pharmacist-provided care offers a convenient and cost-effective alternative to emergency room visits plus addressing health disparities in our state; and (5) patient safety and quality of care is ensured by A.B. 186 defined regulatory frameworks we heard about. Importantly, there is going to be oversight by the State Board of Pharmacy.

The passage of A.B. 186 gives more timely access to care and reduction of strain on our overburdened health care system. Assembly Bill 186 cannot solve all the access-to-care problems, but it sure could help. [Submitted letter in support, Exhibit G.]

Jeani Smith, PharmD, Chief Pharmacy Officer, Nevada Health Centers:
Nevada Health Centers is a FQHC serving patients across Nevada, including in rural and medically underserved communities. I am also a clinical pharmacist who provides direct patient care. I strongly support A.B. 186 because it directly addresses health care access gaps that our patients face daily. In our FQHCs, we serve patients who often wait weeks or even months to see a primary care provider. Pharmacists are highly trained health care professionals who are already embedded in these communities, manage chronic conditions, provide essential preventative care, and also reduce emergency room visits. Allowing pharmacists to prescribe for minor and self-limiting conditions means faster and more affordable care for patients who struggle with transportation, lack of insurance, or need timely treatment. It is not about replacing providers but enhancing team-based care and using every resource available to us to meet the needs of Nevada's most vulnerable patients. I urge you to pass A.B. 186 and thank you for your time.

Jonathan Wolfson, Chief Legal Officer and Policy Director, Cicero Institute:
We are a public policy think tank that works on access-to-care issues and other issues across the country, and we are here in support of the bill. We believe this bill is one way to address Nevada's physician shortage. I have had the privilege of working alongside pharmacists who are in the academy for a number of years. When I began working with them a decade ago, I was not aware of how much clinical training pharmacists had. I had the stereotypical understanding of what pharmacists did and what they were trained to do, but now I fully understand the number of hours of training. In fact, it is over 1,700 hours of clinical training, which is more than double what a lot of other folks with full practice authority and full authority to write prescriptions have. It makes a lot of sense to give expanded skills of practice and allow pharmacists the opportunity to practice and serve those patients. For all those parents who are struggling to try to find care in the middle of the week when they are trying to be at work and have kids who are sick, pharmacies tend to be open on weekends. We support this legislation, and we appreciate the sponsor for bringing it. [Submitted a document in support, Exhibit H.]

[Letters in support, Exhibit I, Exhibit J, Exhibit K, and Exhibit L, were submitted but not discussed and will become part of the record.]

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to A.B. 186. Is there anyone wishing to testify in opposition?

Lea Cartwright, representing Nevada Psychiatric Association:
The Committee has pointed out several areas of the bill of concern, and you will hear more from the house of medicine later on from Nevada State Medical Association (NSMA). On the CLIA-waived test list, if you read through, there are a little over 1,400 of them. I wanted to point out some of the tests that are included that have an impact on psychiatry. These include lithium—your lithium levels—tricyclic antidepressants, benzodiazepines, amphetamine, methadone, buprenorphine, methamphetamine, fentanyl, norfentanyl, oxycodone, ethanol, salvia alcohol, cannabinoids, phencyclidine, barbiturates, and morphine. There are a couple of those tests on that. It is a big list. I have learned more about CLIA-waived tests in the past 12 months than I ever needed to, not having gone to medical school.

Again, the Nevada Psychiatric Association, along with the house of medicine, has several concerns about this bill. It would take a long time to list them out in their entirety. I do not have more than two minutes, so I will pass it on to my colleagues, and I believe there are some physicians on the line. [Submitted letter in opposition, Exhibit M.]

Sarah Adler, representing American College of Obstetricians and Gynecologists, Nevada Section:
We really appreciate the effort to increase access to health care, but we do stand in opposition to A.B. 186. In the words of Dr. Sandra Koch, pharmacists are simply not trained to treat chronic disease. Now, the American College of Obstetricians and Gynecologists

(ACOG) would note they appreciate the ability for pharmacists to dispense contraceptives, and that was put specifically into law because that was an appropriate matchup of a need and a skill set. I also happen to represent the Nevada Opioid Treatment Association, and they did not object to pharmacists becoming able to dispense buprenorphine and suboxone because in rural Nevada, we do not have access to that treatment in the way an opioid treatment program can provide it in an urban area. Again, to repeat, ACOG opposes A.B. 186.

Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association:
The Nevada State Medical Association is in strong opposition to A.B. 186. Increasing access to care is a priority in Nevada, but this bill is not the way to do it. First, there is a valid concern that A.B. 186 could inadvertently place profit motives above patient care by allowing pharmacists to perform the test, diagnose medical condition, prescribe the treatment, and sell the medications. This may lead to corporate pressures on pharmacists that may harm patient well-being.

Most importantly, this bill illustrates it is not always the case that some care is better than no care. This bill can have devastating consequences to the health of patients. The list of CLIA-waived tests is extensive, some of which are complex. While pregnancy and COVID-19 tests may be straightforward, the list also includes complete chemistry panels, lipid profiles, thyroid tests, and glucose monitoring, including A1Cs.

Without adequate clinical training, pharmacists may not be equipped to properly diagnose and treat conditions linked to some of these tests. I have multiple examples from my doctors, but I only have two minutes, so I will give you a straightforward one. If a patient develops worsening fatigue, altered bowel habits, and mildly elevated heart rate since their last doctor's visit, a simple CLIA-waived hemoglobin test by a pharmacist might not capture the underlying issue. In this case, while the test result may remain unchanged, a physician would consider the possibility of other serious conditions, such as a gastrointestinal bleed or cancer, which would necessitate a change in the treatment approach. Without the benefit of a physical exam and a full medical history, the pharmacist may miss these critical signs, leading to a misdiagnosis of continued iron deficiency anemia when the patient is actually experiencing an acute and potentially life-threatening condition.

My physicians are concerned this bill, which permits pharmacists to order tests and prescribe treatment for established conditions without conducting a comprehensive physical exam or reviewing and understanding the patient's medical history, may compromise the quality of care for patients because the CLIA guidelines are so broad.

Passage of this bill creates confusion as to who is responsible for patient care. Pharmacists are not trained in clinical medicine, nor do they establish that long-term care relationship. Will pharmacists have to keep charts on patients and make referrals to specialists? Will they be available for calls and follow-up care? While this bill wants you to categorize pharmacists performing these tests as the practice of pharmacy, it is clear it can be the practice of medicine. We must ensure the quality of care for patients remains a top priority, and for these reasons, we are in opposition.

Nehal Naik, Private Citizen, Las Vegas, Nevada:
I am a board-certified emergency physician and a member of NSMA. I serve patients through the Las Vegas area valley. I am here to oppose A.B. 186. I respect the valuable role pharmacists play in our health care system. I work closely with them as partners in the emergency department, but this bill raises serious concerns. The big thing is that section 1, subsection 1, paragraph (d) allows the pharmacist to determine if there is an emergency that threatens the health of the patient. This seems especially egregious. I am an emergency physician. Everyone I see in the emergency department is there for an acute condition. I need to ensure someone's chief complaint does not show signs of serious illness, and if it does, I address it. How are pharmacists trained in addressing emergencies? Are they providing similar medical screenings I am required to do by federal [unintelligible] regulations? No, they are not.

Let us take that simple strep test. When I see someone with strep throat, I need to examine the patient to make sure they do not have a life-threatening illness, which may occur from a simple strep throat. This includes things like peritonsillar abscesses, retroperitoneal abscesses, or [unintelligible] angina. A lot of jargon, I know, but these can all rapidly progress into an airway emergency requiring intervention. Even for UTIs, if someone comes in with pain during urination, I need to make sure it is nothing life threatening, such as kidney infection or perinephritis, which simply add on the symptoms of back pain. I also look at antibiograms locally, resistance patterns, look at prior urine cultures to see if they have grown drug-resistant bacteria. Can the pharmacist do this? If a pharmacist is able to perform a strep or urine test, are they evaluating the patient with a full history and physical, assessing medical history and risk factors? That is what the practice of medicine is.

Finally, this legislation could exacerbate health care disparities. People in underserved communities with limited access to physicians may start relying on pharmacists for diagnosis. For this, I urge you to prioritize patient safety and the integrity of medical practice and oppose this bill. Thank you for your time and consideration.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to testify in neutral?

Shelly Capurro, representing Nevada Association of Health Plans:
Some of your questions in the conversation are what we are hoping to work towards with the sponsor of this bill. We have administrative and member care issues we are going to be discussing. Proper medical records documenting previously diagnosed health conditions must be available and reviewed prior to the pharmacist prescribing and providing treatment. This is especially important for health conditions that require treatment and management by specialists.

We also recommend the legislation be explicit that if providing medical care and treatment to a Nevadan, a patient-pharmacist relationship is created similar to that of a doctor-patient relationship, especially if the member's health condition requires routine follow-up and continued management and care.

Finally, we recommend that the legislation should include a provision that establishes and outlines the process necessary for pharmacists to submit claims for medical benefit reimbursements. This is especially important since pharmacy benefits and medical benefits are distinct.

Grace Larkins, Private Citizen, Reno, Nevada:
I am both a parent and an advocate for individuals with complex medical needs. Today, I want to introduce a perspective that may be overlooked because the population is small but has an incredibly high need: Nevadans with complex medical conditions who depend on durable medical equipment (DME) for daily survival. I am the mother of a ten-year-old daughter, Lucy, who has a rare genetic disorder, cerebral palsy and epilepsy.

For the past 18 months, I have been working as part of a statewide DME work group focused on improving the cumbersome process of acquiring necessary equipment, such as wheelchairs, incontinence supplies, and feeding tube supplies. Delays and denials are unfortunately the norm. For example, it took over four months to get the new size up of the same diapers for my daughter as she has been wearing for years. It took us a year and a half to get her wheelchair. A teenager in our network needed a simple size adjustment for their walker and had to negotiate numerous appointments and paperwork, waiting almost an entire year.

Durable medical equipment fulfillment often gets caught in procedural loops, creating unnecessary delays and additional costs for taxpayers. These challenges harm patients and place an avoidable strain and cost on the health care system. Last year, our work group discovered that DME providers in Nevada are licensed under the Board of Pharmacy. Assembly Bill 186 is a smart solution to help unclog the broken system and alleviate some of this backlog by allowing pharmacists to authorize routine DME orders, such as size adjustments, incontinence supplies, or replacement parts for mobility equipment. This could help reduce delays and allow specialists to focus on the more complex medical needs.

For individuals with permanent conditions such as cerebral palsy or spinal cord injuries, requiring new authorizations for every supply is burdensome. Streamlining DME access through thoughtful prescribing policies would reduce delays, improve health outcomes, and lower costs, especially in light of the workforce shortages that families like mine feel very deeply every day.

If this bill moves forward, I urge you to consider durable medical equipment in the future discussions. I think it may be a smart solution. It is critical these are addressed in a comprehensive way to meet the demands of Nevadans with long-term, complex medical needs. I thank you for your time and consideration.

Chair Marzola:
Is there anyone else wishing to testify in neutral? [There was no one.] Assemblymember Orentlicher, would you like to give any closing remarks?

Assemblymember Orentlicher:
Thank you very much for your consideration. Of course, I am happy to work to make sure we draw the proper lines and have the right guardrails in place. I will just say, remember we have states doing this already, states that have gone beyond this, and all the opposition testimony you heard, hypotheticals that sounded like a Stephen King novel, but you did not hear anything in terms of data or studies that have found any of the concerns they raised. The studies all show this can be done and is being done in a safe way to increase access and bring down costs of health care.

Chair Marzola:
I will close the hearing on A.B. 186. I will now open the hearing on Assembly Bill 207. This measure revises provisions governing the submission of certain information to the Commissioner of Insurance relating to mental health parity and addiction equity. You may begin when you are ready.

Assembly Bill 207: Revises provisions governing the submission of certain information to the Commissioner of Insurance relating to mental health parity and addiction equity. (BDR 57-853)

Assemblymember Lisa K. Cole, Assembly District No. 4:
I am honored to be accompanied by Spencer Flanders and Dr. Laurie Drucker to help me present this important bill. Mental health impacts every family, every community, and every corner of our state. It does not discriminate by age, income, or political affiliation. It affects hardworking Nevadans who simply want to live productive, fulfilling lives. Yet many of these people are being denied the care they are rightfully entitled under the law. This is not about expanding government or increasing spending. It is about ensuring fairness and accountability in a system that is already in place. We have laws on the books that guarantee mental health parity, but without transparency, those laws are meaningless. If insurance companies are denying legitimate claims, we need to understand the reasons so we can address them.

We believe in personal responsibility, and we know when a person reaches out to a mental health practitioner, they need help, often immediate help. Any barrier to receiving that help can be devastating. Hardworking Nevadans who are covered by health insurance should receive the care they need, and if a claim is denied, it is imperative we understand the why.

This is about transparency and about making our systems work as they are intended. It is about giving Nevadans the tools they need to make informed decisions for themselves and their families. I sit here today not asking for more regulation but for fairness, clarity, and accountability because every Nevadan deserves to know when they need help, the safety net they have paid for will be there.

We have been presented with an amendment. I do not believe that it is in front of you at the moment, but we are working right now on that language to address the concerns regarding trade secrets. Right now, we feel the amendment is a bit too broad, but we do understand the spirit of their proposed amendment, and we are working with them to address the stakeholders' needs and issues. Chair Marzola, with your permission, I would like to pass off the presentation to Spencer Flanders who will give us details and background on this bill.

Spencer Flanders, representing Nevada Psychological Association:
I am here today to discuss Assembly Bill 207, which deals with mental health parity. I do have a presentation [Exhibit N], but I do not see it currently up. It is not on here, but that is okay. Some of you may be asking, What is mental health parity? The simplest term for this is making sure we take mental health care the same as physical health care. We must treat them the same. This is not just me saying this, this is actually put inside federal law in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Quoting right from this Act, it says, "The treatment limitations applicable to such mental health care or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by this plan." What it essentially does is put mental health parity inside of the law. There is a second part to this Act and, specifically, this deals with reporting. I am going to go into the details there. The first part in the reporting of mental health parity is disclosure of medical necessity criteria. When you get your medical benefits, you get an explanation of benefits (EOB), and it is going to say, Oh, you have this amount of doctor's appointments, this amount of physical therapy appointments, and this amount of this and that. Say we had physical therapy appointments, and you had 20 covered, you would need a matching for mental health appointments as well, according to this federal law. In addition to this, you also have the explanations for your denial of mental health claims, which needs to be reported. Any denial of mental health claims gets reported to the Division of Insurance of the Department of Business and Industry.

What is super interesting is that states actually get the ability to enforce this, and it also has oversight with the federal government. Going into how the federal government gets their information, is through the System for Electronic Rate and Form Filing (SERFF). This is developed by the National Association of Insurance Commissioners, and it was required by the federal government for insurance companies. It collects information on denial claims and compliance review. What does SERFF actually do? It collects denial justifications; medical necessity criteria, which is those EOBs we were talking about; appeal information, which is any information between insurance and policyholders; regulatory compliance with the MHPAEA; and [unintelligible] everything and puts it in statistical data points.

There are many different states that use SERFF for mental health parity. We have California, Oregon, New York, Washington, Massachusetts, Tennessee, Ohio, and Arizona. They all use SERFF. I think what is made very clear, too, is every insurance company has to use SERFF for federal reporting. They do not always do it for state reporting, but they use the system in those ways, and it is also used through many different insurance claims. It is a unified system that is very easy to use.

The current issue in Nevada is that we do not use SERFF. We do not use that tracking system. What we do is collect the information through various different forms, which makes it hard to put it into a consolidated area and see what is going on. As much as I would love to help the Division of Insurance with administrative work, our main claim today is we want to have transparency of the MHPAEA. When the Nevada Psychological Association approached the Division of Insurance to get information, we were denied access. This is super important because we are hearing psychologists say claims are being denied, they do not know the reasoning for this, and we want to have some more transparency there. The whole purpose of having this Act is to have the transparency to make sure we are treating mental health care the same as physical health care.

Now, psychologists better than anybody know the importance of making sure their information is confidential. We have claims inside of our bill, which specifically look at making sure we have personally identifiable information not being discussed and not being shared to public record. To discuss this a little more, I would love to pass it off to Dr. Laurie Drucker, who works in psychology.

Laurie Drucker, Legislative Co-Chair, Nevada Psychological Association:
I am a psychologist here in Nevada. We are asking for your support for this bill as part of Nevada's commitment to improving access to care, an issue I know you are hearing about over and over again. Reinforcing mental health parity is vital for allowing individuals to access needed benefits under their insurance plans. I was a provider in 2008 when MHPAEA was passed. Previous limitations on the number of visits, which were often 10 to 12 per calendar year for every mental health diagnosis, was eliminated. Copayments dropped to the same level as those for primary care services and patients who needed to access their out-of-network benefits could afford to do so.

Recently, I have had to ask for prior authorization for a client to access their out-of-network benefits with a deductible so high the insurance company was never going to pay anything towards their treatment. Other insurers are limiting the number of visits again. I have gone back to 12 sessions per calendar year and then have to ask for authorization for more. Understanding what is covered and for how much is often confusing for myself and my clients. Many of my clients pay substantial sums of money out of pocket before their benefits kick in.

The Nevada Psychological Association conducted a survey of mental health providers in Nevada last year to ask about their experiences with the enforcement of mental health parity laws. They routinely reported to us that copayments and deductibles for mental health benefits have significantly risen in the last number of years, making mental health care less affordable for all of our clients. Additionally, they reported they had experienced increased denials for mental health care, requiring extra time to appeal the denials for necessary services. Many reported recoupments, which is when an insurance company takes back money they have already paid for claims when a utilization review committee subsequently

denies the care. They noted difficulty getting credentialed, long wait times, being told panels are full while receiving calls from consumers looking for services who have been told the provider was on their panel but is not. Then we have consistently lower reimbursement rates here in Nevada than in surrounding states.

I waited over nine months to be credentialed with one insurance company after they tried to deny my application on the basis of network adequacy. I am a child and adolescent specialist. Every county in Nevada, as you have heard, has a behavioral health care provider shortage, and Nevada ranks 51st in the nation for access to care for children. When I pointed out these facts, I was invited to credential with them for lower than Medicare standard rates.

Psychological testing is another specialty in the field of psychology that allows us to conduct neuropsychological assessments of autism, attention deficit hyperactivity disorder, and learning disabilities, as well as provide complicated evaluations for individuals with multiple diagnoses as well as for forensic purposes. This is another area that faces significant challenges. Most insurers impose such limitations on the time for administering, scoring, and interpreting tests that many providers cannot afford to bill for these services. Most consumers have to pay out of pocket to get the evaluations to allow their child to receive special education services, receive a clear diagnosis, be evaluated for dementia, or have their psychological status accurately identified in a court of law.

Mental health parity is the law in Nevada and across the nation. Since the federal government required more compliance data from insurers in 2001, almost every state is finding areas of noncompliance with MHPAEA by insurance companies. That is true here in Nevada as well. In this bill, we are seeking accountability and transparency so the data that is being collected here in Nevada can be used to improve access to care for mental and behavioral health services.

Spencer Flanders:
Chair, with your permission, I can do a walk-through of the bill. We are going to go to section 1, subsection 3, paragraphs (a) and (b). What this does is put "in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners" right in statute. On page 3, section 1, subsection 4, you can see we added "personally identifiable information of a consumer" on there, making sure we have our patients' information not being revealed. That is the bill as is. Chair, we are open for questions.

Chair Marzola:
Are there any questions?

Assemblymember Yeager:
Congratulations on your first bill presentation. I think it went really well. Obviously, mental health parity is really important, and I want to make sure I can understand what the bill is trying to do. We have a federal law that requires mental health parity, and we also have federal laws that require insurance companies to present certain information when it comes to denial of claims. What we are trying to do is say they should have to also report that information to the state. Is that essentially what the bill is attempting to do?

Spencer Flanders:
This information is currently being reported to the Division of Insurance. However, it is happening in various different forms. They are kind of receiving memos. What we are trying to do is get a transparency piece so the public can look at this information so we can do an analysis if they are upholding mental health parity.

Assemblymember Yeager:
You want to standardize the information, so what is being reported to the federal government is the same that is being reported to the state? I am seeing heads nodding yes. My question there is kind of twofold. This might be a question for the Division of Insurance, so if it is, we can punt to them. Is there no way for the state to already get that information from the federal government? Is there not information sharing that happens already?

Spencer Flanders:
I do not know for sure, but I am happy to get you that information.

Assemblymember Yeager:
Thank you. I have one more. The information I think is important. It helps us know what is going on. Again, this could be a question for the Division of Insurance. What is the remedy if what we learn through the reporting to the Division of Insurance is that companies are not complying with the federal law on health parity? Is that something the Division of Insurance works on? Does the Attorney General step in? Does the individual have a claim? Does the insurance company have a claim? That is a multipart question. I wonder how this works on the back end on the state level if we know someone is not complying with the law.

Laurie Drucker:
I will take that one. I have been part of a statewide parity compliance task force for the last several months, and they talk frequently about these issues. My understanding is that under the current law, insurance companies, when they are found in violation of a parity reporting standard, they are given an opportunity to correct that. That is the standard. With the transparency, both consumers as well as providers and insurance companies know what is happening, and then it is on the insurance company to correct their standards. If they do not, then it looks at enforcement issues.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] Great presentation, Assemblymember Cole. We will begin with testimony in support of A.B. 207. Is there anyone wishing to testify in support?

Matt Robinson, representing Vegas Stronger:
Vegas Stronger is a nonprofit dedicated to delivering compassionate behavioral health care to underserved Nevadans. We are in support of this bill for its efforts to bring the state into parity with the federal regulations.

Wesley Harper, Director of Government Affairs, City of North Las Vegas:
Thank you for this opportunity to be in support of this bill. The City of North Las Vegas believes that parity and mental health transparency, in order to make sure our residents get the same mental health as physical health, is important, and we appreciate the opportunity for support.

[Letters in support, Exhibit O and Exhibit P, were submitted but not discussed and will become part of the record.]

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to A.B. 207. Is there anyone wishing to testify in opposition? [There was no one.] We will move to testimony in neutral. Is there anyone wishing to testify in neutral?

Shelly Capurro, representing Nevada Association of Health Plans:
We are working with the sponsor and proponents of the bill. We are working through some aspects of the proprietary information. We are looking at *Nevada Revised Statutes* 333.333. That is what we are working through with them, and they are understanding the spirit of what we are looking through.

[Testimony in neutral, Exhibit Q, was submitted but not discussed and will become part of the record.]

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Chair Marzola:
Is there anyone else wishing to testify in neutral? [There was no one.] Assemblymember Cole, would you like to give any final remarks? [There were none.] I will close the hearing on A.B. 207. I will now open it up for public comment. Is there anyone wishing to provide public comment? [There was no one.] Committee members, are there any final comments? [There were none.] This concludes our meeting for today. Our next meeting will be on Wednesday, March 5, 2025, at 1:30 p.m. This meeting is adjourned [at 3:19 p.m.].

RESPECTFULLY SUBMITTED:

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Cynthia Ihejirika
Recording Secretary

RESPECTFULLY SUBMITTED:

_____
Julie Axelson
Transcribing Secretary

APPROVED BY:

_____
Assemblymember Elaine H. Marzola, Chair

DATE: _____

EXHIBITS

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 183	C	Assemblymember Gregory S. Koenig, Assembly District No. 38	Proposed amendments
A.B. 186	D	Ken Kunke, PharmD, Executive Director, Nevada Pharmacy Alliance	PowerPoint presentation titled "Assembly Bill 186"
A.B. 186	E	Assemblymember David Orentlicher, Assembly District No. 20	Conceptual amendment
A.B. 186	F	Netochi Adeolokun, PharmD, Director of Clinical Pharmacy Services, Community Health Alliance	Letter in support
A.B. 186	G	Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative	Letter in support
A.B. 186	H	Jonathan Wolfson, Chief Legal Officer and Policy Director, Cicero Institute	Document titled "Pharmacists Can Fill the Doctor Shortage Gap in Nevada"
A.B. 186	I	Your Care Coalition	Letter in support
A.B. 186	J	Belawoe Akwakoku, Associate Director, State Government Affairs, National Community Pharmacists Association	Letter in support
A.B. 186	K	Shyla Mariano, Private Citizen, Henderson, Nevada	Letter in support
A.B. 186	L	Various Individuals	Letters in support
A.B. 186	M	Lesley Dickson, M.D., State Legislative Representative, Nevada Psychiatric Association	Letter in opposition
A.B. 207	N	Spencer Flanders, representing Nevada Psychological Association	PowerPoint presentation titled "AB 207 Mental Health Parity"
A.B. 207	O	Michelle McGuire, Private Citizen, Las Vegas, Nevada	Letter in support
A.B. 207	P	Steve Shell, Vice President, Behavioral Health, Renown Health; and Chair, Washoe Regional Behavioral Health Policy Board	Letter in support

A.B. 207	Q	Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry	Testimony in neutral