MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND EDUCATION

Seventy-fifth Session
April 6, 2009

The Senate Committee on Health and Education was called to order by Chair Valerie Wiener at 2:50 p.m. on Monday, April 6, 2009, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 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 Valerie Wiener, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Steven A. Horsford
Senator Shirley A. Breeden
Senator Maurice E. Washington
Senator Barbara K. Cegavske
Senator Dennis Nolan

GUEST LEGISLATORS PRESENT:

Senator Terry Care, Clark County Senatorial District No. 7
Senator Maggie Carlton, Clark County Senatorial District No. 2
Senator Bernice Mathews, Washoe County Senatorial District No. 1
Senator Mike McGinness, Central Nevada Senatorial District
Senator David R. Parks, Clark County Senatorial District No. 7
Assemblyman Bernie Anderson, Assembly District No. 31
Assemblyman Joseph (Joe) P. Hardy, Assembly District No. 20

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Mindy Martini, Committee Policy Analyst
Sara Partida, Committee Counsel
Shauna Kirk, Committee Secretary

OTHERS PRESENT:

Mark Rosenberg, D.D.S., M.P.H., Dental Outreach, Saint Mary's
Tyree Davis, D.D.S., Dental Director, Nevada Health Centers, Inc.; Miles for Smiles Dental
Victor A. Sandoval, D.D.S., M.P.H., Professor and Chair, Department of Professional Studies, University of Nevada, Las Vegas
Michael Gerber, M.D., H.M.D., Homeopathic Medical Physician, Gerber Medical Clinic
Bobbette Bond, NV Health Care Policy Group
Chris Giunchigliani
Steve Walker, Truckee Meadows Water Authority
Lori H. Quinn
Janine Hansen, President, Nevada Eagle Forum
Lynn Chapman, Vice President, Nevada Eagle Forum; Nevada Families; Nevada Families Voter Guide
Juanita Cox, Citizens in Action
Juanita Clark, Charleston Neighborhood Preservation
Brian McAnallen, March of Dimes
Jennifer Stoll-Hadayia, Washoe County Health District
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Peter D. Krueger, NV Petroleum Mktrs. & Conv. Store Assn.
Lea Tauchen, Director of Government Affairs, Grocery and General Merchandise, Retail Association of Nevada
Robert Crowell, Mayor, Carson City Consolidated City-County
Nancy McDermid, Chair, Board of County Commissioners, Douglas County
Mary Walker, Carson City; Douglas County
Luana J. Ritch, Ph.D., Chief, Bureau of Health Statistics, Planning and Emergency Response, Department of Health and Human Services
Joseph McEllistrem, Ph.D., Forensic Psychologist, Director, Forensic Mental Health Services, Carson City Sheriff's Office, Douglas County Sheriff's Office
Judge John Tatro, Carson City Justice and Municipal Court
David Schumann, Chairman, Nevada Committee for Full Statehood
John Wagner, State Vice Chairman, Independent American Party
Jack Van Dien, Counselor, SCORE
Steve Hiltz, Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada
Drew Christensen, Director, Office of Appointed Counsel, Clark County

Paul Elcano, Executive Director, Washoe Legal Services
John Berkich, Assistant County Manager, Washoe County
Lynn O'Mara, M.B.A., Health Planning Program Manager, Bureau of Health Statistics, Planning and Emergency Response, Health Division, Department of Health and Human Services
Keith L. Lee, Board of Medical Examiners
Christine Roden, RN, M.P.H., Manager, Primary Care Office, Bureau of Health Planning and Statistics, Health Division, Department of Health and Human Services
Thomas G. Chase, CEO, Nevada Health Centers, Inc.
Patricia Durbin, E.D., Executive Director, Great Basin Primary Care Association
Lawrence Sands, D.O., M.P.H., Chief Health Office, Southern Nevada Health District
Ted Olivas, City of Las Vegas
Laura Hale, Management Analyst, Department of Health and Human Services
Deborah Williams, M.P.H., Manager, Office of Chronic Disease Prevention and Health Promotion, Southern Nevada Health District
Sherri Rice, Access to Health Care Network
Ken Retterath, Chairman, Board of Directors, Access to Health Care Network

CHAIR WIENER:
We will open the meeting with Senate Bill (S.B.) 311.

SENATE BILL 311: Requires the fluoridation of water provided by certain public water systems and water authorities in certain counties. (BDR 40-924)

SENATOR BERNICE MATHEWS (Washoe County Senatorial District No. 1):
This bill requires the Truckee Meadows Water Authority (TMWA) to fluoridate water and provide fluoridated water to approximately 325,000 people or 77 percent of the population in Washoe County. Fluoridation of water is important to protect the dental health of our residents, in particular, our children. It allows a phase-in implementation of the fluoridation process. The first phase requires fluoridation of water at the TMWA treatment plant by October 2011. The second phase requires fluoridation no later than October 2013. This phase allows TMWA to spread the cost over a period of time to reduce the impact on ratepayers. Clark County has been fluoridating their water since 1999.

MARK ROSENBERG, D.D.S., M.P.H. (Dental Outreach, Saint Mary's):
I have a letter in support of S.B. 311 for the record (Exhibit C).

TYREE DAVIS, D.D.S. (Dental Director, Nevada Health Centers, Inc.; Miles for Smiles Dental):
I have written testimony I will read (Exhibit D).

SENATOR NOLAN:
When we first voted to put fluoridated water into the system, most of the opposition came from individuals who claimed that fluorine is a poison at high levels. There was a lot of concern that we would have individuals poisoned by over-fluoridation. Since we have started fluoridating water, have you heard of any cases where people have become toxic because of fluoridation?

DR. DAVIS:
No. It is very well regulated.

VICTOR A. SANDOVAL, D.D.S., M.P.H. (Professor and Chair, Department of Professional Studies, University of Nevada, Las Vegas):
I have written testimony that I will read (Exhibit E).

SENATOR MATHEWS:
Dr. Sandoval, are there any communities you are aware of that have naturally occurring fluoridation in the water?

DR. SANDOVAL:
I do not have that data right now, but I can get that for you.

DR. ROSENBERG:
In northern Nevada, there are two Indian colonies. There is the Nevada Urban Indian Colony that does not have naturally fluoridated water, and there is the Hungry Valley Indian Colony that is naturally fluoridated. There is a significant difference in the dental needs of those colonies.

SENATOR MATHEWS:
Do you know the effect bottled water has had on fluoridation?

DR. ROSENBERG:
We are finding an increase in cavities since the advent of bottled water. Bottled water is usually purified and natural fluoride is taken out of it. In fluoridated communities, the people who drink bottled water have a higher caries rate than those who drink the community water.

SENATOR NOLAN:
Can topical fluoride that you get with toothpaste take the place of fluorine in your water?

DR. ROSENBERG:
People do get some community-fluoridated water when cooking and in some purchased beverages. About 20 percent of the population has 80 percent of the dental disease. This is a way to get through all different socioeconomic levels.

MICHAEL GERBER, M.D., H.M.D. (Homeopathic Medical Physician, Gerber Medical Clinic):
In 2001 or 2002, Washoe County voted against fluoridating the water. Dental decay has nothing to do with fluoridated water. It is a socioeconomic issue and affects the ones drinking high-fructose corn syrup fruit juice and eating an improper diet. There are a number of double-blind studies in the Country that show fluoride has nothing to do with tooth decay. It causes osteoporosis, thinning of the bones and bone cancer. About six or seven years ago, I asked the "Washoe County Water Master" what they put in our water supply. He said that he did not know, but it must be safe. It is not fluorine or fluoride; it is hydrofluorosilicic acid. It has been related to Alzheimer's disease and numerous other illnesses. Third world populations have horrible skeletal fluorosis called "bent leg syndrome." Their backs are so bad that they are carried around on a board with their face down. They also have horrible dental fluorosis where their teeth are orange and brown. If you look at the double-blind studies, you do not see any advantage of fluoridation in the water. Many of the world's leading authorities in New Zealand and Australia have changed their water fluoridation. Even the University of California, San Francisco, School of Dentistry has said that oral fluoride does nothing for cavities. The topical fluoridation may have some use. If you want fluoride, you can buy fluoride tablets or toothpaste.

SENATOR NOLAN:
Parts of the Country have been fluoridating the water for two decades. Why have we not seen fluorosis?

DR. GERBER:
It is a socioeconomic issue. We have high levels of protein, calcium and other vitamins in our food supply, and the fluoride is soaked up in deleterious form. We do have an alarming increase in Alzheimer's disease and dementia as well as osteoporosis.

SENATOR NOLAN:
Does the American Dental Association promote the fluoridation of water?

DR. GERBER:
Yes. Fluoride is not what is going into the water supply. It is environmental, industrial waste products.

SENATOR MATHEWS:
In 2002, there were 59,000 people who voted for fluoridation in Washoe County and 43,000 who voted against it. In 2002, the population in Washoe County area was 102,000 voters. Today there are 230,000 voters.

BOBBETTE BOND (NV Health Care Policy Group):
I am here as a health-care professional and as a mother. I have two children who were born in Las Vegas and every dentist I have taken them to, including in Chicago, North Carolina and Washington, D.C., has told me that water fluoridation, as we have moved through the Country, is the reason they have perfect teeth, and I have bad teeth. I was raised with non-fluoridated water. I did not become interested in dental health until 1996. At that time, I became the participant advocate for the Culinary Health Fund and my job was to make sure I understood where barriers to access and barriers to prevention were. I spent a great deal of time trying to figure out what was going on in Las Vegas in oral health. I am here as a community advocate supporting overcoming the barriers and the misconceptions in Washoe County. I serve on the Community Coalition for Oral Health's board in Las Vegas, and there is not one single thing we could do to provide more cost-effective and more systematic prevention to save the children's teeth.

ASSEMBLYMAN BERNIE ANDERSON (Assembly District No. 31):
I am in support of this bill, and asked Senator Mathews to be a cosponsor. It is an essential part of dental health for children. I have a daughter currently on staff at the University of Nevada, Reno. When she came back to Nevada several years ago, she asked me why we did not have fluoridated water. She said

Colorado and Montana had fluoride. I explained to her that we had missed that opportunity. When my last grandson was born, I told her I would try to make sure they had a better opportunity. This program has been very successful in Clark County over the last five years. The citizens of Washoe County deserve the same opportunity.

CHRIS GIUNCHIGLIANI:
I am here as an individual. As the original sponsor of fluoridation for southern Nevada in 1999, a group of dental hygienists came to me and wanted to do something. At that time, we had the highest number of dental caries in the United States. Over a four-year period, we gathered over 5,000 petition signatures. I was accused of trying to poison people. All the water in the world is naturally fluoridated. This allows you to regulate how much goes in. There are wells in northern Nevada that are over-fluoridated which causes the mottling on the teeth. The problem is over-fluoridation and not under-fluoridation. As Dr. Sandoval said, $13 million has been saved. It is a savings for the economy and the people. Studies are now showing that bottled water is bad for you. We are now seeing an increase in dental caries for our senior citizens because of bottled water. When teaching, I had children who were in absolute agony because of the dental diseases they had. Truckee Meadows Water Authority can regulate the amount of fluoride based on the heat, the time of year and the amount of water people drink.

SENATOR CEGAVSKE:
Is there a fiscal note? This says that it may have an impact at the local level, and it will have one at the State level.

SENATOR MATHEWS:
It will be spread over several years. Most of it will be fee-generated from our water users in Washoe County.

SENATOR CEGAVSKE:
I would like to see the fiscal part of it from southern Nevada as far as how much is charged to the users, and how much they have in an account.

MS. GIUNCHIGLIANI:
Truckee Meadows Water Authority can put those numbers together.

SENATOR CEGAVSKE:
There were issues in a meeting with the Southern Nevada Water Authority that arose, and there was a fee.

MS. GIUNCHIGLIANI:
Yes. There was a minimal cost to the water authority.

DR. ROSENBERG:
Presently, Clark County residents are spending 18 cents per person per year to have their water fluoridated. The annual savings for just last year was $13 million.

SENATOR CEGAVSKE:
How did you arrive at a savings of $13 million?

DR. ROSENBERG:
That is what your Department of Health and Human Services (DHHS) has calculated. That does not include what the State is paying in Medicaid funding to restore the teeth.

STEVE WALKER (Truckee Meadows Water Authority):
The Board of Directors of the TMWA opposes S.B. 311. It is not because it opposes fluoridation. It is an issue of process. The vote in 2002 was against fluoridation in Washoe County. If the bill moves forward, there have to be some issues identified. If you look on page 2, line 22 of the bill, it states "public water system that serves a population of 100,000 or more." There is only one in Washoe County. If the TMWA fluoridates their surface water, it will distribute water to three other water companies that serve far less than that number. What you do not see in the bill is the voting requirement. If you are going to put fluoride in the water, you will have to exempt more than just Clark and Washoe Counties, change the 100,000 and exempt the section where you vote. Right now, you vote for fluoride if you are a water company with 15 connections or more. We would be serving fluoridated water to people who voted against it.

LORI H. QUINN:
I am a daughter of a dentist and a Nevada resident. My mother was strongly opposed to fluoride; my father was for fluoride at that time. People in cancer therapy are advised not to have any fluoride. If fluoride is going to be in our

cooking water, our soft drinks and our concentrated juices, chances are that people going through cancer treatments are going to have a difficult time. There is an advertisement on television for toothpaste that has no fluoride. Nutrition is the reason why the indigent have dental caries at a young age. Dental clinics have jugs of fluoridated water available. If we want to treat the indigent children with dental caries, they can get treatments at the dental clinics.

JANINE HANSEN (President, Nevada Eagle Forum):
I served on the Washoe County ballot committee to oppose fluoridation of the water. This bill does not provide the people a choice. If you are going to force fluoride on us again, we should have the opportunity to vote. I have passed out information on a survey from the Centers for Disease Control and Prevention (CDC) (Exhibit F). The CDC's recent survey found that 41 percent of teenagers aged 12 to 15 years and 36 percent of teenagers 16 to 19 years have dental fluorosis. That means that over one in three teenagers now display a visible sign of fluoride overexposure. This is becoming an increasing problem, as it is 23 percent more than it was in the 1980s. I also have information from the U.S. Army Medical Command concerned with fluoridation (Exhibit G). It talks about brain function being vulnerable to fluoride. They had problems with potential motor dysfunction, intelligence quotient (IQ) deficits, and learning disabilities from fluoride. Epidemiological studies from China showed IQ deficits in children who were overexposed to fluoride via drinking water. Fluoride exposure impaired memory and concentration, and it caused lethargy, headache, depression and confusion. Depression is not something to ignore because suicide occurs more frequently than expected in populations of fluoride workers. There are no advantages to water fluoridation. The risks far exceed the hope for benefit.

I have also given you a copy of *The Professionals' Statement Calling for an end to Water Fluoridation (*Exhibit H). The American Dental Association's policy changed in November 2006, recommending that only water labeled purified, distilled, demineralized, deionized distilled or produced through reverse osmosis be used when preparing infant formula during the first 12 months of life. Formula made with fluoridated water contains 250 times more fluoride than the average 0.004 parts per million concentration found in human breast milk in non-fluoridated areas. They recommend that babies not receive fluoridated water in their formulas. A publication in May 2006 in a peer-review case-controlled study from Harvard found a five- to seven-fold increase in

osteosarcoma, a frequently fatal bone cancer in young men associated with exposure to fluoridated water at six, seven and eight years of age.

The Sierra Club has a position on fluoridated water, which I have given you (Exhibit I). Many of you may remember our former Congressman, Walter S. Baring, who was our single Congressman and a Democrat for many years from this State. He placed on the Congressional record his concerns about fluoride and the civil liberty issues of medicating people through the water. People have many options to receive fluoride, but those of us who are getting it in the water do not have the option. The government should not be force-medicating us through the water. There are many, like myself, with kidney disease who will have additional problems if they have fluoridated water. Those who have diabetes are subject to more critical problems if they drink fluoridated water. Do not take our right to vote. We already voted approximately three times against it in Washoe County.

LYNN CHAPMAN (Vice President, Nevada Eagle Forum; Nevada Families; Nevada Families Voter Guide):
My grandmother lived to be 98 years old with all of her own teeth and did not have fluoridated water. My father is 82 years old has still has all of his teeth. I grew up without fluoridated water, and I still have my teeth. I have given you a copy of some notable quotes, and I would like to read one of them into the record (Exhibit J):

> The American Medical Association (AMA) is not prepared to state that no harm will be done to any person by water fluoridation. The AMA has not carried out any research work, either long-term or short-term, regarding the possibility of any side effects.

There is a lot of information that can be found on <www.nofluoride.com>. I would have had to go through too many reams of paper to bring all of it to you.

JUANITA COX (Citizens in Action):
I have written testimony I will read, but I would like to address Senator Nolan's question first (Exhibit K). He asked if there were any areas that could be identified with naturally occurring fluoride. I lived in the Moana Lane area in Reno, and the water there had too much naturally occurring fluoride. We did not know that. I drank that water and became over-fluoridated and have mottling in my teeth. I also have problems with brittle bones and kidney disease. I cannot

have foods with naturally occurring fluoride, or otherwise, and I cannot bathe in fluoridated water. I also object to the lowering of the population minimum from 400,000 to 100,000.

JUANITA CLARK (Charleston Neighborhood Preservation):
I am representing our neighborhood group, Charleston Neighborhood Preservation. The National Kidney Foundation has withdrawn their support for fluoride. We urge you to let the people vote on this matter.

CHAIR WIENER:
We will close the hearing on S.B. 311 and open the hearing on S.B. 383.

SENATE BILL 383: Requires certain warnings regarding the use of certain tobacco products. (BDR 40-1104)

BRIAN MCANALLEN (March of Dimes):
I am here to speak on behalf of the March of Dimes. I have written testimony in support of S.B. 383 (Exhibit L).

SENATOR CEGAVSKE:
I have problems with the mandate and the costs to the retail owners. I am also concerned about who is going to monitor it. From what I can see, it is the Health Division. Section 2 of the bill states, if you violate section 2, subsection 6, paragraphs (a), (b) and (c), there is a $100 fine and a vending machine is a $500 fine. Where do the proceeds go?

SARA PARTIDA (Committee Counsel):
Pursuant to subsection 8 of section 2 of this bill, any money recovered pursuant to this section goes to the State General Fund to be used for the enforcement.

SENATOR CEGAVSKE:
These signs are expensive. Would a piece of paper printed from a printer substitute for what you are looking for?

CHAIR WIENER:
I just saw a piece of paper Scotch taped to the door in a bathroom, and it satisfied the requirement.

MR. MCANALLEN:
In section 1, subsection 4, paragraph (b) it indicates you can solicit and accept donations of signs that satisfy the requirements from a nonprofit organization or other source.

JENNIFER STOLL-HADAYIA (Washoe County Health District):
The Washoe County Health District supports any efforts that will prevent the use of tobacco during pregnancy. The health district has helped provide affected facilities with signs free of charge in prior measures. We can do something similar if this bill is passed.

LAWRENCE P. MATHEIS (Executive Director, Nevada State Medical Association):
I am speaking for the Nevada State Medical Association and the Nevada Tobacco Prevention Coalition who are in support of the bill. This has worked in other states, and we do support it.

PETER D. KRUEGER (NV Petroleum Mktrs. & Conv. Store Assn.):
The Nevada Petroleum Marketers & Convenience Store Association is in opposition to this bill. Preventing these kinds of health problems is a concern to all of us. However, there comes a point in which we cannot do any more. Our members are required, by law, to post many different types of signs. There is the "We Card;" we have signs about alcohol and other age-restricted products. There is another bill in the Legislature requiring all tobacco products to be moved behind the counter. There is no more room. If we get rid of the point of sale, we could put this sign in the women's bathroom. It is required at a specific point. The bill does not define where a point of sale is. Is it at the cash register? There is no room. Is the point of sale within three feet? I have already talked to Mr. McAnallen, and I am willing to work with them. The other concern is the language in section 1, subsection 4, which says the Health Division can adopt alternate forms. How often does that occur?

LEA TAUCHEN (Director of Government Affairs, Grocery and General Merchandise, Retail Association of Nevada):
The Nevada Retail Association is also in opposition to S.B. 383. There is so much signage at the point of sale that it can be overwhelming for the consumer. If the Committee does move forward with this, please consider a phase-in component for the signage.

CHAIR WIENER:
We will close the hearing on S.B. 383 and open the hearing on S.B. 278.

SENATE BILL 278: Authorizes the establishment of health districts in certain less populous counties. (BDR 40-1061)

SENATOR MIKE MCGINNESS (Central Nevada Senatorial District):
I represent parts of seven counties in Nevada. Several of the residents asked me about this idea. While I am not a large fan of the taxes that are in this bill, I would like you to keep an open mind.

ROBERT CROWELL (Mayor, Carson City Consolidated City-County):
Senate Bill 278 is enabling legislation that would allow one or more counties adjacent to each other to create a regional health district. As many of you know, Carson City already has a health district and has done some wonderful things through that health district. For example, during the Statewide flu shot day, Carson City Health District provided 3,653 free flu shots, which represented 46 percent of all of the flu shots given in the State on that day. Even though Carson City has its own Board of Health, our Board of Supervisors has unanimously requested that this legislation be introduced for your consideration. We believe it goes a long way to creating a synergy with our neighboring counties. This is a way to share services, to relieve State burdens, to create operational efficiencies, to marry concepts of mental and public health and to allow us to provide effective and efficient services to our residents.

NANCY MCDERMID (Chair, Board of County Commissioners, Douglas County):
We did vote unanimously to support this legislation. I also believe in regional cooperation. We already do that in Douglas County. We provide the juvenile detention center, the China Springs Youth Camp and we partner with four other counties in the Western Nevada Regional Youth Center. The model for this was the Carson Water Subconservancy District. This new approach for Nevada has a lot of merit in it. Community health is the umbrella, and instead of remaining in silos, we see that community health involves public health, mental health, environmental components and other possibilities. We see this as a partnership with the State and our sister counties. The health districts are economies of scale that can be maintained. We can eliminate duplicity and redundancy. We can be cost-effective and efficient. We can pool our resources and personnel. We can be inclusive and have nonprofit organizations and other State agencies work with us to identify the services that can be provided by this health district.

When working with Carson City and the adjacent counties, we can reach a threshold that would allow us to qualify for federal grants. Currently, we are unable to do so.

Douglas County wants to be involved in this because our demographics include two high numbers. One is the senior population as well as a high rate of suicide and attempted suicides. The cuts in the mental health program in 2007-2008 and 2008-2009 have affected our county. At one time, we had a waiting list of 25 people to be seen, and now that is 125 people. It will take at least a year for those individuals to get an appointment. If they had other resources, they would be utilizing them, but they do not. The Douglas County Sheriff's Department, District Attorney, courts and emergency personnel have all been affected. Our physicians are telling us that some of the people they are currently seeing have attempted suicide in order to get into the system.

We believe that this enabling legislation would allow us to take a go-slow approach. With Carson City as our mentor, we can look at what 47 other states have already done to provide the services for their local citizens through their community health districts. We would work with everyone to identify programs and services that we could provide. We do not seek to take any other services from any other agencies that are currently providing them. Rather, we seek to collaborate with them to see how we might assist them in providing those services locally. As far as the tax, Douglas County believes in a judicial use of the taxing authority. The people that would incur the taxes are the people that we see every day. In closing, it is good policy.

SENATOR WASHINGTON:
Section 15, subsection 1 imposes 15 cents on each $100 assessed. Subsection 2 imposes a tax rate of up to one-quarter of one percent of the gross receipt tax on retailers within the health district. Section 16 requires that the regulations of the district board of health impose a gross-receipt tax on retailers. Then, there are similar provisions on local school taxes. If this bill gets out of this Committee, you may have to be referred to the Senate Committee on Taxation.

MAYOR CROWELL:
There are two counties here that fully understand your concerns about taxation. This offers, on a policy basis, a very efficient and effective use of services to our citizens. If it has to be referred, I understand that process. The taxing

authority set forth is enabling, and it is capped. We do not anticipate using any or all of that; you will see an amendment from Ms. Walker that is going to talk about getting what we can from the Interim Finance Committee. If the State decides we can take certain services, they will transfer certain budgetary funds that the State gives to the regional health district. That will alleviate the need to impose any tax. Right now, we are asking for enabling legislation to allow us to look at what we can realistically provide on an effective basis. We do not have any desire to impose the maximum amount of that tax. We just want the flexibility to look at what we think we can do that will help the State and our citizens.

SENATOR WASHINGTON:
Would you be opposed to amending the bill and have it go to the Legislative Committee on Health Care working along with the State to come up with a means by which services might be transferred to this district and assess the cost and fees? This has some merit.

MARY WALKER (Carson City and Douglas County):
I have given each of you a copy of a requested amendment (Exhibit M). We have the ability to establish the district, work with the DHHS and come up with an Interlocal Agreement on what services would be transferred and what appropriations would be transferred.

This bill does three things. The Health Division came to our rural counties' commissions and made a presentation asking us to look at a regional health district. We do many things on a regional basis. The problem is we do not have proper governance based on the 20-year history of the Carson Water Subconservancy District. There would be two elected officials from each of the counties to sit on this board. The second thing is bonding authority. Facilities are needed if you are going to provide services. The third thing that it does is provide a revenue stream. That is the second requested amendment in Exhibit M. It revised section 15 to place the ad valorem tax authority in a more appropriate chapter of law.

In the rural counties such as Carson and Douglas County, the sales tax declines are more than double the decline of the State. Our sales tax decline is in the double-digit figures. As of December, there is approximately a 7.5-percent decline. We rely on car sales, and there are no car sales. We are in our third year of budget cuts. The research we have done on this has shown this is

a great model to have federal, State and locally matched funds together to provide these services. With the State's budget cuts, we are having many mental health issues. This is a way that we can partner together, and the only way we can come up with a local match to State dollars and federal dollars through new revenue sources.

SENATOR WASHINGTON:
I remember when we passed legislation dealing with the juvenile justice center for the five counties. We added an additional .5 cents ad valorem tax. With the current property tax, you exceed that by going up to 5 percent. Can you explain that to me?

MS. WALKER:
What we are talking about is 1 percent of the total tax rate. You would look at the district and determine the lowest tax rate within the district. The lowest tax rate, if you had a Carson and Douglas district, is $2.60. That makes 1 percent of $2.60, which is .026 cents you would be able to enact per this amendment. It is not the 15 cents all at once. It is slow and gradual. On an assessed-valued home of $100,000, it would cost approximately $9. The 26 cents is about $9 per home on any year. That would be the limit. We are looking at small, moderate steps. My fear is that if we take on these services, do not have a mechanism for revenue, it fails and becomes a drain, they have to decide whether they are going to fund police or other services.

SENATOR WASHINGTON:
I am supportive of the regional health district, but there are many ancillary issues and services given to the regional health district. Those issues include what the DHHS is willing to give up, what the costs for those services are and the funding. Instead of losing the concept, would it not be better for us to work through it during the interim to come up with something that is workable to the State and the counties?

MAYOR CROWELL:
The way this bill is structured now does essentially that. It just does not have the step of going to the Legislative Committee on Health Care to study it. This bill allows us as respective counties to look at the services we can provide and go to the State and tell them what they are. We think that is a more efficient way to proceed, rather than studying it for two years. As you know,

Carson City is seeing the effect in our jails and hospitals. This is a reasonable mechanism for us to go forward.

MS. MCDERMID:
We took a long time to develop this. We believe that the governance issue allows for the requirement of a two-thirds vote of the board. It is made up of two county commissioners from any county that would join; it would require one positive vote of the county commissioners in order to put any tax forward. In starting the process now, we will be ahead of the game. There is a holistic approach to community health. That is what we want to do. We do not want to take on a service that we cannot effectively and efficiently provide. We see this as a partnership which can be a model or pilot program for other counties in the State. Individually, we cannot take it on as one little county. If we can do this and work together with the State, when we come back in two years, we will have something that will take the State into the twenty-first century regarding our approach to community health.

SENATOR WASHINGTON:
Have you spoken to DHHS?

MS. MCDERMID:
Yes.

LUANA J. RITCH, Ph.D. (Chief, Bureau of Health Statistics, Planning and Emergency Response, Department of Health and Human Services):
I have provided written testimony, and I will highlight the key points (Exhibit N). The DHHS is committed to working with communities to go forward with the maturation of a local health district and the provision of services at the community level.

CHAIR WIENER:
Is the amendment being proposed something your division and the counties could work with to formulate the holistic, integrated system?

DR. RITCH:
The Health Division is committed to ensuring a seamless transition working with the county or the health district entity as we do with Carson City, the Southern Nevada Health District and Washoe County.

SENATOR WASHINGTON:
The amendment says the transfer of the services must be approved by the Interim Finance Committee. Was there a reason why you selected the Interim Finance Committee as opposed to the Legislative Committee on Health Care to transfer services?

MS. WALKER:
I went over this language with Mr. Willden, and he approved it. If there is another mechanism that will work better, we would be happy to work with you on that. If you are transferring services, there will be some finances transferred.

JOSEPH MCELLISTREM, Ph.D. (Forensic Psychologist, Director, Forensic Mental Health Services, Carson City Sheriff's Office, Douglas County Sheriff's Office):
We have seen a rather dramatic paradigm shift in the way that people are offered services in our communities nationwide. In fact, many of our clients who need inpatient psychiatric care are getting it in jails and prisons. It has been said before that jails and prisons nationwide have become some of the de facto psychiatric or hospitalization programs. We had deinstitutionalization in the 1950s. There were a large number of individuals coming out of that system going into more community-based, outpatient-based mental health care. There is always a subpopulation of individuals who cannot be treated at that level of care. It was much too low. There was the criminalization of mental illness and we had people who were getting into minor legal entanglements because of their mental health issues. There was a revolving-door system in place. In the Carson and Douglas jails, we see a lot of that. There is no access to care for many of these individuals. It becomes a legal matter, because we do not know what else to do. In jails and prisons nationwide, about 16 to 24 percent of the population base has a severe mental disease defect. It costs twice as much to treat people in the community as it does in jail. If you treat them in emergency rooms, the costs go up. When they come to emergency rooms or to us, they are in crisis. All we can do is stabilize them. It is not ongoing preventive care. It becomes very expensive; they are in and out of custody and on and off their medications. It is a fractured health-care system to provide mental health care out of a jail.

JUDGE JOHN TATRO (Carson City Justice and Municipal Court):
Mental health court is analogous to what the consolidated district would do. We have a mental-health court team that sees people once Dr. McEllistrem has seen

them in the jail. We have several different ways they are referred to us, but they have to have been arrested. They come to court and end up in mental health court. Our team consists of me, the district attorney, a public defender, a caseworker from Carson Mental Health, a counselor from Carson Mental Health, and substance abuse counselor, the City Department of Alternative Sentencing and the State Department of Parole and Probation. We attempted to use Carson Mental Health years ago to do evaluations in the jail when we had someone who was suicidal or had serious issues. We would go through an administration that would send someone to evaluate for a few months and then stop because the administration at the State level would change. It was better to have it local. The City contracted with Dr. McEllistrem, and that has been a godsend to our City and the people arrested with mental issues. We take a team approach to every individual with mental health issues. Nobody comes to mental health court who does not also have medical or dental issues. They always have problems because they have not been taking care of themselves; they are off medication and their hygiene is not good. We take them to a dentist or a doctor. Carson City is where people from surrounding counties come to work and commit crimes. I send people to Reno Mental Health Court, Judge Blake sends people to me and Judges Gamble and Gibbons send them from Douglas and Lyon Counties. We provide the consolidated care, and it is successful. The team approach works at the local level as opposed to the State level.

DAVID SCHUMANN (Chairman, Nevada Committee for Full Statehood):
This is an incredible bill. It has almost unlimited taxing authority without a vote of the people. Europe has been doing this for a century. The result is fewer physicians per hundred people and lower standards of treatment. I know they say this is not socialized medicine, but it is the first step towards it. It is unmistakable. There is a 100-percent probability that, as this process goes on, there will be lower pay for physicians. People are coming to America from the "free system" in Canada by the thousands. The reason they are coming is they get a lower quality of health care under the government. Mixing government with medicine always results in low quality medical care. This has been tried across the world. A friend of mine in London had to wait 8 months to get a cavity filled because they rationed health care. At the same time that Nevada is thinking of doing this, the federal government in the "Porkulus Bill" has a program that is instituting observers. The federal government will have a director of this information technology who will sit with your doctor as you are treated and advise the doctor that he is or is not following proper procedures. The boards we are talking about are ruled by nonphysicians. There is

one physician on the board and several politicians. Anybody who is getting medical care from the government is on welfare. I would like to see what evidence Dr. McEllistrem has that says people with a mental disease would seek treatment before they go to jail.

JOHN WAGNER (State Vice Chairman, Independent American Party):
Carson City already has what it needs. It is Douglas and Lyon County that do not have what they need. It is to their advantage to team up with us. They are already sending people to us, and we are picking up the tab. If we have to pick up the tab for their citizens, then we should be billing them for the services. Last year, Carson City had a ballot measure for public safety. Carson City voters voted "no" on that and the Virginia and Truckee Railroad tax. I do not like the idea of agencies raising taxes without the vote of the people.

MS. HANSEN:
This Session, we have seen three bills similar to this in which the counties would overthrow the State's authority to raise taxes, be allowed to circumvent the property tax cap, be allowed to circumvent the vote of the people and be allowed to impose these taxes without the vote of the people. This is a serious policy change, which is of significant concern to anyone who is struggling every day to pay his or her taxes. The board is not elected, and we cannot go to them and say we are angry that you are raising our taxes. There is no real accountability to the people with taxing authority in their hands. They can obligate us in general-obligation bonds. On page 4 of the bill, it mentions noticing and where they will hold meetings. It does not talk about noticing the public, and they can move the meeting around to wherever they want. That makes it difficult for the people to go to meetings. It states that if no one appears who will be directly affected by the proposal and requests a hearing, the district board of health may proceed immediately to act upon any written submission. Does that mean that since I no longer live in Washoe County and they want to put fluoride in the water, I cannot come to testify? Does that mean people on Medicaid cannot come and testify because they are only taxpayers and not directly affected by it? I do not know what that means. I am very concerned about imposing taxes with no accountability. It also provides for a county treasurer who can be designated to keep track of this or appoint some other qualified person to fill the office. We have a county treasurer that is elected, and there is accountability. I do not see accountability to the people for whoever will be responsible for these millions of dollars.

Page 6 of the bill talks about allowing people to come to share their feelings about the decisions they are making. It is a serious issue to be even thinking about allowing any kind of an agency or county to be imposing taxes without the review of the Legislature.

MS. COX:
I have written testimony I will read (Exhibit O). I live in Storey County and will get only one representative on the board. This bill gives us no due process or accountability.

JACK VAN DIEN (Counselor, SCORE):
The proposed health district appears to have little redeeming value for county taxpayers and citizens lacking information to the contrary. I am alarmed at the tax and debt authority they want. In a presentation made to the Douglas County Commissioners, the sales pitch was from proposers who would expect to become the district's medical officers and perform the functions now delegated to the State. There should be a business plan set up for this type of organization that clearly sets out the revenues, the cost, the manpower and the amount and type of services performed before any legislative action is taken. It has been my experience with Douglas County that if they have taxing authority, they will use it. Currently, county taxpayers have almost exclusive control at the ballot box over the amount of tax they must pay for county services. The people requesting these health districts want too much control of taxpayers' pockets. The proposed legislation includes no provision for any kind of control by taxpayers. Legislation should require the minimum of a series of published public forums arranged to reach all areas of the counties affected. The hearing at which this was discussed was held in South Lake Tahoe. Meanwhile, 80 to 90 percent of the Douglas County population lives in or near Carson Valley. There have been no public hearings and no attempt to learn what the public reaction might be.

CHAIR WIENER:
We will close the hearing on S.B. 278 and open the meeting on S.B. 292.

SENATE BILL 292: Adopts the Uniform Representation of Children in Abuse, Neglect, and Custody Proceedings Act. (BDR 38-1025)

SENATOR TERRY CARE (Clark County Senatorial District No. 7):
There is no affect on the State from a fiscal point of view, but it does contain an unfunded mandate. Clark County thought that the bill might cost them $10 million. The Uniform Law Commission has recently converted it into what is called a "model act." They are not looking for states to enact the Uniform Act in totality, but to choose those provisions that a state might think will work for them. Because there is a disparity across the Country of representation of children, where there is a guardian ad litem or a court-appointed attorney in abuse and neglect and termination of parental-rights cases, they thought there was enough of a disparity that this issue was right for uniformity. It has some terms in it that we have not seen in this jurisdiction, such as the best interest's attorney and the children's advocate and the children's attorney. Those are all different roles, and there is language about the fact that the court would consider before determining what role any of those attorneys of advocates might have in the representation of a child in any one of these three types of proceedings. It is now a model act. If the Legal Aid Center of Southern Nevada and Washoe Legal Services feel that there are provisions in this bill they can use and testify to those, that is fine. If this bill has provisions in it that helps those organizations, and it is in the best interest of the children, that is fine. I would encourage them to come forward and explain why that would be the case.

STEVE HILTZ (Directing Attorney, Children's Attorney Project, Legal Aid Center of Southern Nevada):
Our unit started about nine years ago. We were formed to represent some of the children in the foster-care system. Prior to that, no child in Nevada received representation of any kind. Throughout the Country, in almost every jurisdiction the size of Clark County, there was an attorney appointed to every child coming into the foster-care system from day one. We are way behind the curve. Over the last nine years, we have added approximately one attorney a year. We now have eight full-time attorneys doing this work. We have a pro bono component of about 180 attorneys. We represent a little less than 50 percent of the children in foster care. I am an attorney with a client. My client's lives are affected severely by what happens in the court system and by what happens to them once they are placed under the care of a large government bureaucracy. They desperately need representation. Every day we see how the children's lives are affected for the better by having an attorney speak for them in court. These children suffer neglect, and they come into our system and receive further neglect. I can only imagine how the other half of the children with no representation is treated. There was a 13-year-old boy badly abused by his

father and brought into foster care. He was in a great home for two years and was thriving in a magnet high school. His father received counseling and classes, and after two years, it was decided to return the boy home. Immediately, the father started abusing him again. The boy was brought back into the system, and I began to represent him. He desperately wanted to go back to the home he had been in, and the home had a bed available. The foster care agency decided that the boy was better in his mental health, and the level of care was too high. They said "no." He needed a lawyer to file a motion with the court demanding that he be placed in the foster home that was clearly best for him. The agency was very bitter because they were afraid of not getting Medicaid reimbursements or that they were not doing their jobs properly. Without an attorney, I do not know what would have happened to him. There are children every day who need that type of service to be reunited with their siblings and to get appropriate mental-health service. Everything about a child's life is affected by the court process and decisions made by social workers.

CHAIR WIENER:
One of Senator Care's recommendations was to pick the pieces that could work so it does not get bogged down with the fiscal impact. What we need is something by tomorrow that would be workable in the current climate as a starting point.

DREW CHRISTENSEN (Director, Office of Appointed Counsel, Clark County):
The numbers we came up with are based on my office's evaluations of what we currently pay parents. Institutionally, we have an office within the county that provides legal assistance to either the mother or the father. In a conflicting situation, we contract with private attorneys to represent the other parent. That is costing us approximately $1,600 to $2,000 per case. In Clark County for 2008, there were 1,300 petitions filed. We did determine that there would be significant impact in the millions of dollars. The extreme number is from the concern of how the courts would interpret those children who are already in the system. We have approximately 3,500 children in Clark County that are in "out-of-home" placement and still being monitored by the courts as well as thousands of children who are in "in-home" placement and still being monitored. Under the current statutory scheme, the court's have the discretion to appoint an attorney. The mandate to appoint an attorney in every case is overly broad.

CHAIR WIENER:
Does the fiscal note we have been working with based on that suggested recommendation still stand?

MR. CHRISTENSEN:
It could. We may have to appoint multiple attorneys where there are siblings. We were conservative with the 1,300 petitions. There are at least 1,300 children at the $2,000 figure, making it about $2.6 million before you consider any brothers and sisters. There are 3,000 already in the system's "out-of-home" placement. It would obviously be in the millions of dollars.

PAUL ELCANO (Executive Director, Washoe Legal Services):
Washoe Legal Services provides child advocacy in Washoe County and currently represents 400 children. We have 1,000 children in custody in Washoe County. These cases deal with five issues: where the children are going to live, medical needs, mental health needs, who they will see and how they are going to be educated. In our system, it costs $1,500 per child a year. What is applicable and critical to all of us is the requirement that each child get an attorney. There is a sliding scale of difficulty of the cases. The bill deals with many things that attorneys already do. The legal service community agrees that each child should have his or her own attorney.

JOHN BERKICH (Assistant County Manager, Washoe County):
Washoe County supports the goal and the intent of this legislation. Washoe County is looking at about a $100 million deficit in our general fund through the fiscal year 2010, and that is where we fund the contract. With this legislation, we are estimating the costs to be from $500,000 to $2 million per year on top of the $500,000 that we already spend providing this needed representation. The staff has advised me that we could submit to the Committee by tomorrow details of the fiscal impact. There is a suggestion to assign this to the interagency committee that was proposed under S.B. 344 and to do an interim study working with the various local jurisdictions and the providers in developing a sustainable funding mechanism for this.

SENATE BILL 344: Authorizes the Director of the Department of Health and Human Services to create an interagency committee to evaluate the child welfare system. (BDR 38-475)

CHAIR WIENER:
We will close the hearing on S.B. 292 and open the hearing on S.B. 229.

SENATE BILL 229: Establishes the Physician Visa Waiver Program in the Health Division of the Department of Health and Human Services. (BDR 40-368)

SENATOR MAGGIE CARLTON (Clark County Senatorial District No. 2):
During the interim, I was asked to serve on the J-1 Visa Advisory Committee that was formed. You may all remember a number of newspaper articles that talked about the problems that were happening with our J-1 visa documents. I thought it was important to deal with some of the problems that have been brought to light. The Advisory Committee has taken all non-legislative corrective actions they can take. Being a member of the Legislature and on that committee, they asked me to introduce a bill to deal with the other protections we feel are important for the State to institute to make this a better program. You have a copy of the "Nevada State Health Division's, Presentation to the Senate Committee on Health and Education, J-1 Visa Waiver Program for Foreign-born Physicians" (Exhibit P, original is on file in the Research Library).

LYNN O'MARA, M.B.A. (Health Planning Program Manager, Bureau of Health Statistics, Planning and Emergency Response, Health Division, Department of Health and Human Services):
I have written testimony I will read (Exhibit Q). I will walk you through our proposed amendment (Exhibit R). By making the fee contained in the bill non-refundable, it would help ensure that the applications submitted are in earnest and that the physician intends to provide medical services in Nevada. Applications are received throughout the State's fiscal year, and there are no application deadlines. Therefore, expending all fees received within the State fiscal year may not be possible. Amending the bill to include the provision that unused fees not be reverted to the General Fund would support oversight. The Committee may want to consider including language in section 12, which would allow penalties for certain actions by employers of the J-1 visa physicians.

KEITH L. LEE (Board of Medical Examiners):
This is an excellent piece of legislation made even stronger by Ms. O'Mara's amendments to it. We are offering an amendment to make it clear that the J-1 visa physicians are licensed in Nevada already or have applied for licensure (Exhibit S). We want to make clear that the J-1 visa physician be licensed or have an application pending for licensure when he goes through this process.

There is also a proposed amendment to section 6,adding a new subsection 4, Exhibit S. If the Committee goes forward with that, the staff is going to have to work it because the introductory paragraph talks about the employer or the visa physician. In this case, the license or application pending requirement would apply only to the J-1 visa position. I have shared this amendment with the sponsor and Ms. O'Mara, and they have no problem with it.

CHRISTINE RODEN, RN, M.P.H. (Manager, Primary Care Office, Bureau of Health Planning and Statistics, Health Division, Department of Health and Human Services):
These 41 physicians provide approximately 207,000 medical services per year in Nevada. It is an impressive program.

MR. MATHEIS:
This issue came up in a series of award-winning articles in the *Las Vegas Sun* in the fall of 2007. It really brought home that a key part of Nevada's strategy for dealing with the professional workforce shortages was in peril. We have to recruit physicians not only from around the Country, but from around the world. The program that does that, the J-1 and H1-B Visa Waiver Program for physicians, had a number of problems that were identified in that series. As a result, we have made some recommendations to the Legislative Committee on Health Care and to the Health Division. Richard Whitley, M.S., Administrator, Health Division, Department of Health and Human Services, Lynn O'Mara and Christine Roden all deserve accolades for embracing reforms that otherwise would have been easy to bureaucratically stuff and wait for the Legislative Session. Instead, they embraced them, setting up a primary advisory committee. We have addressed virtually every issue that was raised by the series of articles and by the investigations that were done by the Health Division staff. This bill now makes sure that we enshrine in statute the authority of the Health Division to make sure we take what we have learned to the next step. We are now developing what is probably the nation's model program in how states need to monitor this federal and state joint activity. I get a lot of calls asking how it is that we have been able to turn this around. These programs were on automatic pilot and assumed by everyone that they knew how they worked. They have changed, and as they have changed, it is not always for the better. The Legislative Committee on Health Care and the Health Division has really helped a great deal. There have been a lot of volunteer hours. When we go out into the market for physicians that have come to the United States to do their residency

training, we will have a reputation as a place to go to further develop their careers.

SENATOR CEGAVSKE:
Senator Carlton, have you seen the amendment and talked to them about it?

SENATOR CARLTON:
Yes.

SENATOR CEGAVSKE:
Will the fiscal note be taken with the application fee? Do you have an amount that is being charged?

MS. O'MARA:
Currently, we do not charge an application fee for our J-1 application. What is being proposed is a cap of $500, which would be shared with the two deficiencies. There will be better oversight with unannounced site visits to make sure that everything is as it should be. There is also an educational piece that is missing. There is an orientation of the employer, the physician and even their attorneys that would help resolve some of the deficiencies we find at the front end.

SENATOR CEGAVSKE:
Is the application fee from the doctor? That is what I am trying to define.

MS. O'MARA:
It would be a split fee both the J-1 visa physician and the employer would pay. It is capped at $500. The starting amount would be determined in regulations.

SENATOR CEGAVSKE:
Do they have to be a physician in Nevada? I thought this was an application to become a physician.

MS. O'MARA:
They have to be a physician. They complete their residency, and if they desire to get an H1-B Visa, they can apply to work in our underserved areas instead of going home for two years; they can get an H1-B Visa right away.

CHAIR WIENER:
We will close the hearing on S.B. 229 and open the hearing on S.B. 306.

SENATE BILL 306: Authorizes the Health Division of the Department of Health and Human Services to establish a grant program to support the expansion of various health care services. (BDR 40-1052)

SENATOR CARLTON:
I need to disclose that I am employed part-time as a Community Development Director of Great Basin Primary Care Association, a nonprofit organization that promotes access to affordable, comprehensive and quality health care for Nevada's underserved population. As Nevada's federally designated primary-care association, Great Basin may possibly be eligible to apply for some of the grants available from the grant program established in S.B. 306. Since we are the State's designated program, we do not know what the criteria for these grants could be. We may end up being a partner. That is the reason for this disclosure. Therefore, pursuant to Senate Standing Rule Number 23, I will not be advocating for the passage of this bill. Subsection 12 of Senate Standing Rule Number 23, specifically allows introducing S.B. 306. Although I cannot advocate for the bill, Rule 23 allows me to provide you with factual information relating to the bill.

THOMAS G. CHASE (CEO, Nevada Health Centers, Inc.):
You have my written testimony, and I will only hit the highlights (Exhibit T). You also have an exhibit that speaks volumes about the federally qualified health centers' (FQHC) program in our State (Exhibit U). It outlines the stimulus funding that was recently received by all of our FQHCs across the Country on March 26. That funding was allocated and there was a formula attached to it. Specifically, the formula was $100,000 per grantee, $6 for every patient served by those grantees and $19 for every uninsured patient served by those grantees. The funding formula results in Nevada having a share of approximately $1,464,000 amongst its two FQHCs. That ranks us 51st out of 51 states and the District of Columbia in terms of federal funding per capita.

On the other hand, when you take that same $1,464,000 and divide it by the number of grantees we have, which is 2, we rank 1st out of 51 states and the District of Columbia. The bulk of the funding in that formula is based on two-thirds of volume and performance. That shows that it is not a dominator variance that created the 1st out of 51; it is a performance variance. You have

a tremendous resource in your FQHCs in this State. It is a resource that, if leveraged appropriately, properly and effectively, can result in those kinds of results for patients all across the State.

We still have opportunities to leverage the stimulus funding beyond the increased demand for services (IDS) funding that was made available to all of the FQHCs. Approximately $1.5 million is going to be issued to FQHCs for capital projects. Some of that funding will be formula-based. We expect to get a chunk of change by allocation. For every $500,000, Nevada health centers would expect to get approximately $1.5 million. At the same time, a substantial portion is going to be competitive. It is our understanding those competitor projects will average $6 million. In competitive projects, $6 million can do wonders for the uninsured and underserved in the State. Those projects, however, will also require the participation of the State and communities in order to demonstrate the support that is necessary to sustain them.

By definition, the stimulus is a two-year package. It is that type of funding that is going to allow us to be very competitive and effective. Nevada is not in the mainstream in terms of not funding FQHCs. My former state of Indiana funded FQHCs in 2008 to the tune of $30 million.

SENATOR CEGAVSKE:
The amendment asks for $300,000. Why is that not in the original bill?

SENATOR CARLTON:
When introducing the bill, the people from the health centers had not been to Washington, D.C., yet and had not learned what the potential for funds might be. Because of the deadlines, we made the decision to get the bill drafted and into the pipeline. Once we got the information on what might be available, this was the figure that was worked out to maximize the potential within the competitive grants.

CHAIR WIENER:
Is the money in the amendment a one-to-one match?

MR. CHASE:
I do not believe it will be a one-to-one match. The matching requirement will likely be 5 or 10 percent. The average award for the competitive side is going to be about $6 million.

SENATOR WASHINGTON:
We introduced a bill last Session that lingered in the Senate Committee on Finance because they did not have the appropriation. I do not recall hearing from the DHHS whether there were any matching funds for FQHCs.

SENATOR CARLTON:
We are preparing that testimony and do not have those answers for you now. There is money there. I just cannot tell you the exact line.

PATRICIA DURBIN, E.D. (Executive Director, Great Basin Primary Care Association):
There is more than one stimulus package. This is not the same stimulus package that comes directly into Medicaid and those areas of the State. There is a specific federal stimulus package for community health centers. There is one directly from the federal government to the U.S. Health Resources and Services Administration (HRSA) and to the Bureau of Primary Health Care that is specifically for community health centers.

SENATOR WASHINGTON:
I would like to have our staff look that up.

SENATOR CEGAVSKE:
Because of the fiscal note, I do not know if we can do anything but send it to the Senate Committee on Finance.

MRS. PARTIDA (Committee Counsel):
I do not know how they are handling those.

CHAIR WIENER:
We will look into that before we process this measure.

SENATOR WASHINGTON:
I think the variables are still there.

SENATOR NOLAN:
We are seeing more and more language of "to the extent that money is available." Does that specifically allude to the funding that is available for the particular project, or what we are referencing in statute? Does it refer to General Funds available or any money available?

MRS. PARTIDA:
That refers to any money available for this purpose. As originally drafted, this bill did not have any appropriation in it. It could have been through stimulus money or some other source. In this case, the intent would be to capture any stimulus funding that is available.

MR. CHASE:
The stimulus bill, American Recovery and Reinvestment Act of 2009 provided $2 billion in funding for FQHCs. The first piece of that was the $340 million that was allocated, and you can see how it was done in the chart, Exhibit U. There remains, after other funding for new access points that was done, $1.5 billion for FQHCs alone. We have to actually apply for these funds from HRSA. It has always been there. It has not been part of what the State recognizes it gets in the stimulus package.

SENATOR WASHINGTON:
Now I understand what you are saying.

CHAIR WIENER:
We will close the hearing on S.B. 306 and open the hearing on S.B. 322.

SENATE BILL 322: Provides for the establishment and maintenance of an integrated system for the provision of health and social services in certain counties. (BDR 40-1073)

MS. GIUNCHIGLIANI:
I am here speaking as an individual in support of S.B. 322. I have written testimony I will read (Exhibit V). You are being handed some suggested amendments (Exhibit W).

What Humboldt County and San Diego did was put together an entire model. What they looked at was operational principles. The branches provided interrelated programs for children, families and adults and would deliver their coordinated, efficient services and maximize resources available for delivering those services. You could have close proximity. The integrity of specialized services could actually be preserved and even promoted. Services could be tailored to the multicultural and multilingual diversity of our community. The partnership between the counties' services and community-based organizations such as the federal health centers would actually be far better capitalized.

Newly identified monies then could be reinvested into health and human services. We in government tend to bifurcate everything we do. It is mostly tied to who has the power, who has the vote and who has the money. This is what we are asking to do now through the amendment. We want to put together a working group to plan for how we can integrate health and human services in the local government and plan out a truly integrated model. There could be administrative savings and human resource savings. That is the intent of S.B. 322. As I suggested, the amendments came backwards and gave everything to the health district. That was not the intent. I made this set up with Senator Parks more as a phase-in, transitory planning stage.

SENATOR WASHINGTON:
Do you need enabling language to do this?

MS. GIUNCHIGLIANI:
Yes. We need the State to participate.

MRS. PARTIDA:
In order to carry this out, they would. If it is simply to come back with recommendations, they would not.

MS. GIUNCHIGLIANI:
There is some angst about who would oversee what. I do not want that to be the focus.

SENATOR WASHINGTON:
Is the bill to oversee or come up with a plan with all the various agencies to provide services?

MS. GIUNCHIGLIANI:
That is the amendment.

SENATOR WASHINGTON:
Do you need a bill to do that?

MS. GIUNCHIGLIANI:
We needed legislation to enable us to move forward with the planning stages for the collaborative model. If you have some people who do not wish to participate, then you will never have a plan that is brought back to you.

CHAIR WIENER:
It is to get a buy-in from the State as well as the other jurisdictions.

SENATOR CEGAVSKE:
Page 3 of your amendment states, “However the departments shall not waive regulations pertaining to privacy, confidentiality of records ... .” Is this existing language?

MS. GIUNCHIGLIANI:
Yes. I took this out of some of the statutory Health Insurance Portability and Accountability Act of 1997. I feel that is important that it is understood.

SENATOR CEGAVSKE:
Is this something that our staff did or did you do it?

MS. GIUNCHIGLIANI:
I did it.

SENATOR CEGAVSKE:
What we need is to make sure that we captured everything that is required by the statute.

SENATOR NOLAN:
Was this something that the Board of County Commissioners in Clark County had approved, or is this being forwarded by you with the help of Senator Parks?

MS. GIUNCHIGLIANI:
I did not bring it to the Board of County Commissioners for position. Our staff has been working on it and brought me the model that health and human services had in San Diego. When you are dealing with commissioners, it is best to advocate what you believe in. They have not taken a position ”for” or “against.”

SENATOR WASHINGTON:
Are we pawning off services to the State, or is the State pawning off services to the county?

MS. GIUNCHIGLIANI:
The State would get out of some of the business of delivery and the counties would do it.

CHAIR WIENER:
The amendment is the first step to getting the "go forward and come back." This would be giving the State the responsibility to participate in the conversation. According to your concerns, they need legislation to send them on their way.

CHAIR WIENER:
We will close the hearing on S.B. 322 and will reopen it again later. We will have a work session now and come back to the remaining bills on the Agenda, Exhibit A. We will start with S.B. 286.

SENATE BILL 286: Establishes provisions relating to early intervention services. (BDR 40-637)

MARSHEILAH D. LYONS (Committee Policy Analyst):
As a member of the Legislative Counsel Bureau, I may not advocate for any legislation that comes before this body. At the Chair's request, I will be walking the Committee through the measures that are in the work session tonight. Senate Bill 286 has a brief summary on page 2 of the work session document (Exhibit X, original is on file in the Research Library). An amendment was proposed and presented at the hearing by Senator Cegavske. The amendment is on page 3 of Exhibit X.

SENATOR NOLAN:
Can Senator Cegavske give us a brief explanation of the amendment?

MRS. LYONS:
During the testimony, there was some agreement brought forward by individuals interested in the bill. One was the performance audit. I understand that Senator Cegavske worked with Paul Townsend to develop that language. The first makes sure the Health Division focuses on certain services and the development of those services for early intervention for infants and toddlers.

CHAIR WIENER:
Senator Cegavske worked with the different voices that came to the table. There was agreement for the audit; then she built consensus around one other consideration to be included in the amendment.

SENATOR CEGAVSKE:
Three or four entities came up. The audit is the cost that came in, because they wanted yearly audits. They are going to ask for one audit and revisit it after we get the results. Everybody has signed off on it.

SENATOR WASHINGTON MOVED TO AMEND AND DO PASS S.B. 286.

SENATOR NOLAN SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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SENATOR CEGAVSKE:
You mentioned there were some issues with S.B. 290. I have not heard from anyone. We had worked out all of the amendments with both of the parties.

CHAIR WIENER:
We rolled it to another work session.

SENATOR CEGAVSKE:
Amendments were made for the two concerns that came forward.

CHAIR WIENER:
We will open the hearing on S.B. 303.

SENATE BILL 303: Enacts the Interstate Compact on Educational Opportunity for Military Children. (BDR 34-186)

MRS. LYONS:
Senate Bill 303 is on page 10 of Exhibit X. An amendment was proposed by Senator Nolan. The Legislative Counsel Bureau's legal staff, and the legal staff for the military officers worked on this amendment.

SENATOR CEGAVSKE MOVED TO AMEND AND DO PASS S.B. 303.

SENATOR HORSFORD SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR WIENER:
We will open the meeting on S.B. 378.

SENATE BILL 378: Establishes requirements for certain early childhood education programs. (BDR 34-1134)

MRS. LYONS:
There were no amendments proposed for the bill. The fiscal note attached to the bill from the Department of Education has no fiscal impact. Although the requirements of the bill will have an impact on the Department of Education staff, it is believed that current Department staff can meet the requirement to develop a plan for early-childhood education within this State without additional fiscal impact.

SENATOR HORSFORD:
I support the bill, but I am concerned about adopting regulations for the curriculum portion. Pre-K includes both private and public programs. How will that be addressed with the adoption of those academic standards and curriculum?

SENATOR WASHINGTON:
There are some federally sponsored Pre-K programs. I am not sure how those regulations will affect that program either.

CHAIR WIENER:
We will hear this bill tomorrow or Wednesday to get that question answered. We will close the hearing on S.B. 378 and open the hearing on S.B. 391.

SENATE BILL 391: Revises provisions relating to charter schools. (BDR 34-1221)

MRS. LYONS:
You will find S.B. 391 on page 50 of Exhibit X. There were no amendments proposed for this bill.

SENATOR HORSFORD MOVED TO AMEND AND DO PASS S.B. 391.

SENATOR WOODHOUSE SECONDED THE MOTION.

SENATOR CEGAVSKE:
Is this for all charter schools, and who is determining that someone is at risk? How is a child defined as "at-risk?" The language also states "certain charter schools." Does that mean that it does not apply to all of the charter schools?

SENATOR WASHINGTON:
This bill works in conjunction with the Andre Agassi College Preparatory Academy. There is a problem with those who wish to enroll their children in the school and are not "at-risk" or disadvantaged. To get around the "at-risk" provisions, they used addresses within that location to enroll their children. The open enrollment stays open enrolled. There is a lottery system for "first come, first served." It precludes the "skirting" of those children who really do not live in that area. The definition of "at-risk" students is the students who receive a free or reduced lunch.

SENATOR CEGAVSKE:
I am concerned about doing something specific for one school. Many schools are "at-risk."

SENATOR WASHINGTON:
Andre Agassi is the only charter school I know that has this problem. They still have to abide by federal and State requirements as far as open enrollment is concerned. This just gives them the leverage to vet those applications to make sure they meet the requirements of "at-risk" students. The open enrollment applies for everyone.

MRS. PARTIDA:
The definition of "at-risk" as it is used in these sections would apply to a pupil who has an economic or academic disadvantage as such that they require special services and assistance to enable them to succeed in educational programs. The term includes, without limitation, pupils who are members of

economically disadvantaged families, pupils who have limited English proficiencies, pupils who are at risk of dropping out of high school and pupils who do not meet minimum standards of academic proficiency. The term does not include a pupil with a disability. As it is being applied in this bill, it would be any charter school providing services to those pupils.

SENATOR CEGAVSKE:
Who is making these decisions? Is each school deciding who the "at-risk" student is?

MRS. PARTIDA:
A statement would have to be included in the original application for the charter school. A statement of whether the charter school will enroll pupils who are in a particular category of "at-risk" pupils and the method of determining eligibility would have to be included at that time and approved.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR WIENER:
We have colleagues who need additional information on S.B. 290 and will be hearing that another day. We are also holding S.B. 319 for the sponsor.

SENATE BILL 290: Authorizes patients of certain facilities to install electronic surveillance devices in the room of the patient. (BDR 40-852)

SENATE BILL 319: Revises provisions governing certain reports of sentinel events and related events. (BDR 40-828)

CHAIR WIENER:
We will reopen S.B. 322.

SENATE BILL 322: Provides for the establishment and maintenance of an integrated system for the provision of health and social services in certain counties. (BDR 40-1073)

SENATOR DAVID R. PARKS (Clark County Senatorial District No. 7):
As revised, Senate Bill 322 would leave the Southern Nevada Health District as it is currently structured and integrate health and social service throughout a unified service-delivery system. This is a family-focused and community-based system, reflective of the business principles in which services are delivered in a cost-effective and outcome-driven fashion. Senate Bill 322 allows county commissioners who have district health departments the option to reorganize their public-health function to provide a broad range of health and social services while promoting wellness, self-sufficiency and a better quality of life. Stacy Shaffer had to leave, but she has given her testimony to the staff for the record (Exhibit Y).

LAWRENCE SANDS, D.O., M.P.H. (Chief Health Office, Southern Nevada Health District):
I have written testimony in opposition to this bill that I will read (Exhibit Z). Our Vice Chair for the Southern Nevada Health District, Steve Kirk, was also in Las Vegas for testimony but was not able to stay. You do have a copy of his testimony (Exhibit AA). At the most recent Board of Health meeting, the Board did go on record as opposing S.B. 322.

CHAIR WIENER:
Have you had an opportunity to review the amendment proposed?

DR. SANDS:
Yes.

CHAIR WIENER:
Is your position the same?

DR. SANDS:
The position is the same. The major thrust of the amendment was to change to all of the services, including the District Board of Health, to come under the county instead of having all of these services come out of the District Board of Health. That is something that the District Board of Health has gone on record as opposing. They feel they operate best as a multi-jurisdictional, regional entity.

SENATOR NOLAN:
Do we have representatives from the Clark County Commission that are signed up to speak? Does the entire Board of Health oppose this?

DR. SANDS:
Correct. We had a quorum of approximately ten members when we discussed S.B. 322.

SENATOR NOLAN:
To refresh my memory, there are representatives from the Clark County Commission and from each of the local municipalities representing those interests on the Board.

DR. SANDS:
Correct.

ASSEMBLYMAN JOSEPH (JOE) P. HARDY (Assembly District No. 20):
I am sitting here before you as Dr. Hardy with the Southern Nevada Health District. However, I am currently on leave from the Health District. My position has nothing to do with any vote the Southern Nevada Health District took. I look at public health as a unique entity in that it is interested in public health. I have a bit of fear when looking at lumping things together that may dilute the intent or the ability to react to public health issues. The director of the public health's entity should be a physician specialist with training in some specialty of management in public health. This bill is trying to fix something that will be fixed somewhere else. We are looking at many different fixes regarding what happened with Hepatitis C. I enjoy the current jurisdictional representation that we have with the Southern Nevada Health District. We have everybody at the table. Everybody has a voice and everybody goes to their respective entity and reports back; then they report to the Health District the issues and concerns of their constituents. We should also recognize that whether it says we are going to lump everything under the District Health Department, or the county, the issues are still the same. The lumping is not as clean as taking care of public health issues would be otherwise. I do have a problem with the amendment as it is written. On the second page, after line 11 it says, "any client shall have access to his or her medical information and shall have the right to correct any inaccurate information ... " Exhibit W. That opens up an interesting door when keeping track of medical records. When we correct a medical record, for instance, we do not redact it; we change it, clarify it or correct it, but it is a process where we do not take something out; we add something in. I would be curious if anybody has looked at the legalities and liability. There are mistakes made that have to be corrected, but there is a way to do that without having

the person change the medical record. To do this by July 2010 would be problematic.

SENATOR CEGAVSKE:
Commissioner Giunchigliani referenced an issue that I did not have her elaborate on, and I am hoping you can. She talked about the clinic issue and what happened regarding whose territory it was.

DR. SANDS:
The feedback we have gotten from other entities is that up front the response worked very well. There was never a question about our authority to be able to do the investigations that were done to uncover the unsafe practices. Because the State has the authority to regulate health facilities, we had to partner with the Health Division. That would be a normal partnership. Similarly, with the different licensing boards, we do not have the authority as a local health district to regulate the practice of nursing or any other licensed health profession. We report and partner with them. We have all learned how we are all interconnected through that investigation. The other issue that we dealt with in the County Commission and with the Las Vegas Metropolitan Police Department had to do with the medical records taken by the Las Vegas Metropolitan Police Department from a licensed facility licensed by the Health Division. No local health district has the authority to possess those records. Information on those records is needed to do investigations, but it does not require actual possession.

SENATOR CEGAVSKE:
Who investigated from the police department?

DR. SANDS:
The police from the criminal investigations require that for evidence.

SENATOR CEGAVSKE:
Did you get the records to find patients that had been infected and notify them?

DR. SANDS:
Those records were made available to our investigators in order to get the information.

SENATOR CEGAVSKE:
Did that go smoothly?

DR. SANDS:
Yes. We have been working collaboratively with law enforcement and the agencies involved.

SENATOR CEGAVSKE:
Where is the Commissioner's frustration?

DR. SANDS:
I do not know.

SENATOR NOLAN:
Can we let Dr. Sands finish his written testimony, Exhibit Z?

DR. SANDS:
I will continue that testimony, Exhibit Z. Having worked for a county health department, people regularly would say, "Oh, you are the county health department." It is very different here. I do not get that in southern Nevada. We are Henderson's health department, the City of Las Vegas's and north Las Vegas's health department. No one can say that we are the health department of another jurisdiction coming in to infringe on another jurisdiction. I have heard that kind of thing might happen if we were to move in this direction. It is a very valuable tool and very important. I know that we would be able to respond quickly and flexibly. One of the things mentioned in the amendment is that the cities are left out of any discussion about this integration. If you look at your statutes, cities have the opportunity to choose to either be part of a district health department, county health department or have their own city health department. If we go that route, we may potentially end up fractioning how we deliver public-health services.

SENATOR CEGAVSKE:
The Commissioner mentioned San Diego has a model. Is that something that can be incorporated over time?

DR. SANDS:
What I know about that model is what I have read from their Website. There are a couple of items you should know. The agencies that were integrated into this larger health and human service agency were already county agencies. They did not have a regional, multi-jurisdictional representation, commissions and boards like the Southern Nevada Health District, the Regional Transportation

Commission and the water authorities. It appears to me to be more of an internal integration of existing services. The other was the timing. The timing began in the 1990's, and 1996 was when the welfare reform was hitting. There was a good opportunity for them to look at leveraging that opportunity to achieve a particular end. I am not saying that it does not exist here, but we need to be careful and purposeful about moving forward in a direction such as this.

SENATOR CEGAVSKE:
Do you have no connection with the county?

DR. SANDS:
No. In statute, the health district is formed as a separate unit of government. In 2005, there was a reformation of the district board of health where the makeup of the board was changed to have more representation from elected officials from each of the governing bodies within Clark County. It also included for the first time a funding line based from property tax that is collected from all the different jurisdictions.

SENATOR CEGAVSKE:
How connected are you to the State Board of Health?

DR. SANDS:
We are connected to the State Board of Health because they have jurisdiction over all public health matters.

TED OLIVAS (City of Las Vegas):
I am here to testify in opposition to this bill. I did not talk to the bill's sponsor prior to this hearing. I did not know it was being amended in this fashion. Senator Washington mentioned earlier that there was some confusion on this, and I share that confusion with the way this amendment was written. This bill is, as I heard in the original testimony, to do a transition process or study. I do not read this proposed amendment as doing that. It says the health district is going to the county. On page 1, line 15 it states "Section 1, authorizes the board of county commissioners to place any county agency which provides health or social services under the direct control and supervision of the county," Exhibit W. That is clear to me. It goes on to say that the county establishes a team to integrate that. I can appreciate that, but the City of Las Vegas supports a regional approach to this Board. It makes sense. Everybody has a vote on that

Board. If consolidation of this Board needs to be considered, I would suggest that we do a study to fully deliberate the pros and cons of such consolidation. If it saves money, then maybe it is the thing to do. If there are best practice models, we ought to look at those. We do not want to make a major change like this, and do it in a vacuum like this bill and the amendment is proposing.

CHAIR WIENER:
We will close the hearing on S.B. 322 and open the hearing on S.B. 340.

SENATE BILL 340: Revises provisions governing the allocation of certain money from the Fund for a Healthy Nevada. (BDR 40-1133)

MS. STOLL-HADAYIA:
I have written testimony with a proposed amendment to S.B. 340 attached (Exhibit BB).

SENATOR CEGAVSKE:
What was your reason for going to the Health Division instead of the DHHS?

LAURA HALE (Management Analyst, Department of Health and Human Services):
It is just to clarify that rather than the monies coming to the Department, then going from the Department to the counties and into the Health Division that it would go through the Health Division to the counties and then to other service providers.

SENATOR CEGAVSKE:
Is the Department agreeable to that?

MS. HALE:
Yes.

SENATOR CEGAVSKE:
You are trying to streamline it, but there is still the accountability measure from the Department on how the money is funneled.

MS. HALE:
I will be testifying for Maria Canfield, Chief, Bureau of Child, Family and Community Wellness programs for the Health Division, who is in support of S.B. 340. You have a copy of her written testimony (Exhibit CC).

SENATOR WASHINGTON:
This is a good bill.

SENATOR CEGAVSKE:
What are our funds in the Funds for a Healthy Nevada, and how did you get your statistics on the 10-percent reduction of smokers?

MS. STOLL-HADAYIA:
There are two primary sources for data on adult and youth smoking rates that Nevada uses, as well as the nation. You are able to compare your state to other states and to the nation for an average. That is the Behavioral Risk Factor Surveillance System (BRFSs) and The Youth Risk Behavior Survey (YRBS). In Nevada, we have also been able to conduct the adult-tobacco survey as well, but it is not as comparable to other states, because it may not be administered in the same way. The BRFSs and the YRBS are consistent. They are comparing apples to apples, comparing state to state and the state to the nation. They do have some of the same limitations that you have itemized. They are self-reported studies, and they are telephone surveys. There are efforts at the national level to improve those methods for data collection. We use the BRFSs, adult-smoking percentage, which is a question asked of people surveyed for this process. We look at those numbers before these programs begin and to the most current number that we have, which is 2007, and that shows approximately a 10-percent drop in the percentage of adults who report that they are current smokers. The same process applies for those who are youth smokers.

SENATOR CEGAVSKE:
To whom are they reporting?

MS. STOLL-HADAYIA:
They report to the federal government and to the states. It is a national system and states conduct the surveys; those are rolled up to the federal level and you have a full picture. It is actually conducted at our Nevada State Health Division, at least for Nevada for the BRFSs. For the YRBS, it is conducted by our Department of Education. It is still at a state level and rolled up to the federal level, and we are able to compare ourselves to other locations.

DEBORAH WILLIAMS, M.P.H. (Manager, Office of Chronic Disease Prevention and Health Promotion, Southern Nevada Health District):
I have written testimony that has been sent to you in support of this bill. (Exhibit DD).

CHAIR WIENER:
We will close the hearing on S.B. 340 and open the hearing on S.B. 380.

SENATE BILL 380: Provides for the establishment of a program of shared responsibility for access to health care for certain uninsured persons. (BDR 40-1132)

SHERRY RICE (Access to Health Care Network):
Access to Health Care Network is in support of S.B. 380. We are the first nonprofit medical discount plan in the State. The Internal Revenue Service tells us we are the first in the United States. We have our 501(c)(3) nonprofit status, and we are registered with the Division of Insurance for the State. Our mission is simple. It is access to care for the uninsured who meet our income guidelines, which is 100 to 250 percent of the poverty level. We follow a shared-responsibility partnership model. We are located in Washoe County and serve the Washoe County area. We will be expanding to the northern Nevada rural areas, thanks to a generous appropriation grant from Senator Reid. Our expansion will extend to the rural areas this summer. As a shared-responsibility model, we have asked something of everybody in our community, but have tried not to overburden anyone. The two hospitals that are the linchpins for this program are St. Mary's Regional Medical Center and Renown Health. The hospitals have stepped up to the plate with this program and given our members the unheard-of rate at either hospital of $400 a day, all-inclusive, in-patient rate. If you go into St. Mary's or Renown and have anything done, including surgery, it would not cost more than $400 a day. Then we asked for the maximum rate per admission of $3,000, which means if you are in either hospital for a month, it would not cost you more than $3,000 for your total inpatient stay at either hospital. Then we ask for the rate of 35 percent of Medicaid-allowable for all outpatient procedures. For example, a $15,000 hernia surgery is $300, a breast biopsy is $165, every lab test is only $5 and even a magnetic resonance imaging (MRI) that is $4,000 is $250. Every single outpatient procedure is discounted to 35 percent of Medicaid-allowable. We have over 500 providers signed on, under contract, to Access to Health Care Network in the Washoe County area. These 500 providers include comprehensive care that is primary care, mental health,

dental and vision, specialty care, diagnostic and ancillary. Ancillary includes podiatry, chiropractic, durable medical, physical therapy, speech therapy, occupational therapy and acupuncture. We have surgery, hospital and pharmacy.

As I said, over 500 providers, 350 of them specialists, are signed on to Access to Health Care Network and under contract for reduced rates for our members. Their reduced rates are based on either a Medicaid or a Medicare percentage. Our members are northern Nevada residents. They have to prove that with a Nevada energy bill, a driver's license or rental agreement. Our members are not eligible for Medicare, Medicaid or Nevada Check-Up. They are not currently on employer-sponsored insurance. Our members have to show photo identification and meet our income guidelines. Because we are a medical discount plan, we paired a nonprofit with a for-profit component that is a medical discount plan. We are registered with the Division of Insurance. It allows us to be a membership program. Our members have to pay a monthly membership fee. They can come in as individuals. We take people individually who meet all of those guidelines, or because we are registered with the Division of Insurance, we can offer this to employers for their currently uninsured employees. That employer cannot have had the employee on their health insurance. That employee has to meet all of our guidelines. We offer to that employer the option to put their uninsured employee on to Access to Health Care Network for $20 a month from the employer and $20 from the employee. That gives us a sustainable dollar component. No employer can drop their current insurance on an employee for 12 months and come on to Access. No employee can drop their current insurance for 12 months and come on to Access. We did not do this to increase the number of uninsured. We have 75,000 uninsured people in Washoe County alone. We did not want to add to the number. We also know that at least 30,000 of the 75,000 are part-time employees. They are never going to be offered a product. We will even take somebody on a wait list to get their insurance product. I can guarantee you that in coming to Access to Health Care Network, no one is going to declare medical bankruptcy. Our rates are too cheap. Our members have to pay cash at the time of service that is nonnegotiable. Two no-calls or no-shows to any of my providers or any nonpayment, and we will ask them to leave the Network. They can never come back. The Network is a privilege. In the last year and a half, we have put 3,000 people onto this program. I have only had to ask 10 members to leave for nonpayment. I have never had to ask someone to leave for a no-call or no-show. It is incredible how this program has been embraced. Our members follow the

rules. We also enroll the insurance industry into what we are doing. Hometown Health and St. Mary's both sit on the Board. Valerie Clark, an independent broker sits on the Board. We put together a committee to help us put our rules together that includes many people in the insurance industry. They are very much a part of Access to Health Care Network. We knew that a family of three at 100 percent of poverty and grossing $18,000 a year could have trouble paying cash at the time of service. There is no preexisting clause. We know that if you have a long-term illness like cancer, even at our reduced rates, you could have trouble paying cash.

We put together a patient-care fund that takes grants, endowments and private dollars. Any member of Access who cannot afford cash at the time of service can apply to this fund. If we have the dollars, we will pay half, because it is a shared responsibility. We have received over $400,000 in donations to this fund for certain segments of our population. We now pay two providers for human immunodeficiency virus, HIV, and acquired immunodeficiency syndrome, AIDS, patients who are uninsured and at our poverty level. We pay directly to the specialty provider so they can get their care. We have money for women with breast cancer. We have money for children who are mentally, emotionally, physically and learning disabled. We do autism treatment and diagnosis out of our fund at reduced rates. We also pay for the first primary care and the first dental visit for every child that comes into Access to get them into the system. One of the things that I want to stress is that only 20 percent of our members come from employers. The other 80 percent come from individuals who are not offered a product and never will be offered a product. They take it upon themselves to come into Access for the care they need. Some things have surprised us about this program and some things have not. We are the first of its kind in the Country, which is why we have received so much national attention. One thing that surprised us is how few employers will take advantage of our program to pay even $20 a month. These are employers who do not insure their employees now; they do not have to pay the $20, and they will not pay the $20. In closing, we believe that every single person should have an insurance product. We believe we have put together a shared responsibility model where we ask something of everyone.

CHAIR WIENER:
There have been concerns that there are employers who would opt to pay less of a premium. You mentioned that an employer who would participate cannot convert to yours for 12 months. How many have done that?

MS. RICE:
We have safeguards with the insurance industry to keep that from happening. If an employer calls and asks about Access, we find out who their broker is, and we personally call their broker and tell them they have an employer interested in Access to Health Care Network. What we seek out is the part-time employee and small business that has never insured their employees.

CHAIR WIENER:
How many employers are in your network?

MS. RICE:
Only 20 percent of our members come from employers. We have about 42 employers. There are 6,749 employers with 1 to 10 employees.

CHAIR WIENER:
Are they employers that would not otherwise provide any insurance?

MS. RICE:
Yes.

KEN RETTERATH (Chairman, Board of Directors, Access to Health Care Network):
This has been an extremely successful program in Washoe County. It has really filled a gap. Individuals who have not had access to a plan have been able to use this program to get needed services. People dropping their insurance to come on to Access were a major concern of brokers and providers. That has not been the case.

CHAIR WIENER:
Is this a model that someone who understands the business could take and run with it?

MS. RICE:
We have other states that would like to replicate our model. We look at whether it would be a technical component. We have made all of the mistakes. When you look at the particular details of this program, we have narrowed down one point of entry in each hospital, because our members have to pay cash. We would consult with other states and would have to offer all of our manuals. It would depend on whether someone would literally come and drive it or whether we would be a technical component that would be consulting. We do not take

ownership of this in any way that would impede it from benefiting people all over the United States. We could be a technical component that could help somebody put it together in a way that maintains the integrity of the program with the safeguards. We could literally expand it to another part of the State as we are doing in the rural areas where it is literally an Access to Health Care Network that is monitored and controlled. Quality control in this program is everything. We have safeguards for our providers, employers, members, hospitals and for the community at large. I also have amendments (Exhibit EE). About 13 percent of our members are either disabled or unemployed. Without the amendment to section 1, we would not be able to address that.

SENATOR CEGAVSKE:
Do you want to mandate that the employer would have to pay for it?

MS. RICE:
We want to require the payment of annual fees by participants in the medical-discount plan and, or, their employer, if employed.

MRS. PARTIDA:
Would you just state the intent for me, and we can figure out the language?

MS. RICE:
The intent is to allow those whose employers, if employed, would not pay the $20 so the employee can come in on their own as an individual member. People can come in individually or they can come in through their employer.

SENATOR CEGAVSKE:
Did we not have to have legislation for you to do this originally? Why are we looking at legislation now?

CHAIR WIENER:
I was asked to bring this as a measure by people who were interested in seeing this as a program and policy of the State. We will now adjourn the meeting of the Senate Committee on Health and Education at 8:02 p.m.

RESPECTFULLY SUBMITTED:

Shauna Kirk,
Committee Secretary

APPROVED BY:

Senator Valerie Wiener, Chair

DATE: