MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
March 24, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:35 p.m. on Thursday, March 24, 2011, 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 Allison Copening, Chair
Senator Valerie Wiener, Vice Chair
Senator Sheila Leslie
Senator Ruben J. Kihuen
Senator Joseph (Joe) P. Hardy
Senator Ben Kieckhefer
Senator Greg Brower

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Shauna Kirk, Committee Secretary

OTHERS PRESENT:

Marla McDade Williams, B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services
Leslie A. Johnstone, CEBS, Executive Director, Health Services Coalition
Steve Winters
Bill M. Welch, Nevada Hospital Association
Joseph Greenway, Director, Center for Health Information Analysis, School of Community Health Sciences, University of Nevada, Las Vegas
Bobbette Bond, M.P.H., Executive Director, Nevada Health Care Policy Group, LLC
Bill Bradley, Nevada Justice Association

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Helen M. Robbins, Hospital Corporation of America, Sunrise Health System
Jeff Ellis, Vice President, Chief Financial Officer, Corporate Benefits, MGM Resorts International; Health Services Coalition
Russell Rowe, Boyd Gaming Corp.
Rusty McAllister, Professional Firefighters of Nevada
Christine Bosse, Renown Health
James Wadhams, Nevada Hospital Association
Chris Collins, Las Vegas Police Protective Association
Jack Kim, United Healthcare Services, Inc.
Thomas Reid, Assistant Executive Director, Las Vegas Police Protective Association
Cynthia Kiser Murphey, President, Chief Operating Officer, New York-NewYork
David A. Silverberg, M.D., Vice President, Nevada Orthopaedic Society
Marilyn G. Wills, Interim Director, Bureau for Hospital Patients, Office for Consumer Health Assistance, Office of the Governor
Lawrence P. Matheis, Nevada State Medical Association
Bret W. Frey, M.D., President-Elect, Nevada American College of Emergency Physicians
Karen Massey, Chief Administrative Officer, Northern Nevada Emergency Physicians
Susan Fisher, Nevada Anesthesia Patient Safety Pac
Kimberly K. Everett, CPM, Assistant Chief, Life and Health Section, Division of Insurance, Department of Business and Industry

CHAIR COPENING:
We will open the meeting with Senate Bill (S.B.) 264).

SENATE BILL 264: Revises provisions concerning the regulation of certain medical facilities. (BDR 40-15)

SENATOR SHEILA LESLIE (Washoe County Senatorial District No. 1):
Nevada is behind many other states regarding the public reporting of health-care quality information at the facility level. We know that public reporting is an essential element in both patient education and safety improvement. This bill is intended to supplement what is currently in statute and help fill the holes that remain in health-care quality and transparency reporting.

Senate Bill 264 has several components identified by the *Las Vegas Sun* series "Do No Harm," as well as input from constituents with loved ones receiving health care and discussions with our state agencies about current capacity.

This bill redefines the term sentinel event. When this legislation passed in 2003, the term "Sentinel Event" was the term used most often by The Joint Commission to identify an unexpected or unanticipated health outcome that injured, or could injure a patient at a health-care facility. Since that time, several new terms have been introduced, including "adverse events," "near miss events" and "never events." It has been confusing to determine if a negative patient outcome should be captured on the sentinel events registry as originally intended. This legislation attempts to establish common and simple definitions and reporting. While the term "adverse health event" is included in this bill, the intent is not to limit the events that must be considered adverse. I understand that those people dealing with these terms regularly may have an alternative suggestion.

Both this bill and S.B. 209 require the sentinel events registry to become publicly reported by a facility. It is just time to do so for the patients of this State. We want to see these events reported publicly on a state-supported Website such as Nevada Compare Care or the Department of Health and Human Services (DHHS) Website.

Last Session, Senator Breeden made great progress in the reporting of facility-acquired infections. This bill requires that those infections which must now be reported to Centers for Disease Control and Prevention through the National Healthcare Safety Network be publicly reported by hospitals. Patients need this information, and research shows that the best way to reduce facility-acquired events is to report them publicly. This is an effort to speed up a reduction in facility-caused infection rates.

The Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services, found that 1 in 5 Medicare patients discharged from a hospital were avoidably readmitted to a hospital within 30 days. This accounts for $17.4 billion of the Medicare budget. We do not know how much of the Nevada Medicaid budget it represents. This is why tracking and reporting of preventable readmissions is also included in Senator Breeden's bill before you today. Obviously, preventable readmissions are major causes of health-care cost and a multitude of problems for patients. It simply is not acceptable for patients

to leave a health-care facility and then return to it unnecessarily. Since Medicare and Medicaid are both making policy decisions not to pay for these preventable readmissions, we think patients should know what Medicare knows. We want Nevada to protect our Medicaid families as well as our dollars. We also want this information publicly reported.

This bill also allows the Health Division (HD), DHHS, to use money collected as administrative penalties to do broader training activities as needed to improve quality of care.

Finally, this bill corrects an issue that arose during implementation of A.B. No. 146 of the 74th Session. This bill mandates that information about specific adverse events that were to be collected and maintained will now be required to be publicly reported. This was the original intent of A.B. No. 146 of the 74th Session, and I hope we can accomplish it this year.

I personally have also been touched by this issue when my cousin, a recently retired judge in California, entered a hospital there last year for a routine operation, caught a severe strain of a hospital-acquired infection and died. In his memory, and in the memory of others who have been injured or have died, I ask for your careful consideration of these bills.

SENATE BILL 209: Revises provisions relating to reports of sentinel events and related information reported by certain medical facilities. (BDR 40-193)

MARLA MCDADE WILLIAMS (B.A., M.P.A., Deputy Administrator, Health Division, Department of Health and Human Services):
The HD administers the provisions in the bill that go through section 15. After that they become the jurisdiction of the, Division of Health Care Financing and Policy (DHCFP), DHHS. We are working with the Nevada Hospital Association as well as Senator Leslie to ensure that we all can come to an agreement on what we want in those sections. We have also talked to the hospital associations associated with some of the terms in the bill format.

LESLIE A. JOHNSTONE, CEBS (Executive Director, Health Services Coalition):
We represent over 270,000 Nevadans from 23 different health plans. Similar to what we testified about on S.B. 209, we have a continuing commitment towards making quality indicators available to the public and the health plans so they may make informed decisions. By having the tools available to make better

purchasing decisions, the cost of health care overall for the affected employers would be improved. The Health Services Coalition (HSC) was one of the main financial supporters for DHCFP's Nevada Compare Care in 2007. This bill continues that foundation, and we support S.B. 264. We are interested in defining the terms in such a way that they are linked to industry standards and would not require continual update through statute or regulation.

STEVE WINTERS:
When my mother died in June 2010, it was published in the *Reno Gazette-Journal*. She was infected with five hospital-acquired infections. As a consumer, I was not aware of that. I got a call at 5 a.m. because the hospital was rushing her to Renown Regional Medical Center. I was only aware of her having a urinary tract infection. We waited for over eight hours to get into the intensive care unit. When I got home that night, I heard a doctor talking about Clostridium difficile infections and that there is no cure for them. I received a telephone call from a lady in Las Vegas who read the newspaper article. She also had been infected with Clostridium difficile and almost lost her life. The doctors did not tell me about these infections, and now I am suffering. I am worried about other people having to go through the same thing. I researched hospital infections on the Internet and found a report that showed our State has significant deficiencies in the area of infection control and prevention. This report specifically identified sterilization and disinfection as the most significant causes of concern for potential health-care associated infections and outbreaks at the ambulatory and surgery centers of Nevada. These inadequate infection-prevention measures can lead to the introduction of pathogens that may result in infections and other complications. Disinfection sterilization is essential for ensuring medical and surgical instruments and equipment do not transmit infectious biological agents to patients. It is puzzling and disturbing that after experiencing a major blood-borne disease outbreak associated with unsafe injection practices in Las Vegas in 2008, inadequate disinfection sterilization practices continue to occur. Inadequate disinfection sterilization on surgical instruments, failure to comply with significant scientifically based guidelines of proper disinfection sterilization and lack of compliance of infection prevention control principles have led to numerous national infectious outbreaks that could have been avoided.

BILL M. WELCH (Nevada Hospital Association):
The Nevada Hospital Association is in support of this bill.

SENATOR BROWER:
What happens when a hospital has a sentinel event or an adverse event? For example, in the Navy when there is an accident, all operations but combat stop until everyone is assured that the same type of thing cannot happen anywhere else.

MR. WELCH:
The hospital has a multitude of safety policies and procedures in place. If an incident qualifies as a sentinel event, it would be reported. There are staff, policies and procedures for immediate intervention. There is a monitoring process and an evaluation process that evaluates each incident and directs the hospital to take the steps necessary to prevent it from happening again. We use a process referred to as "root cause analysis." As these types of events occur, a monitoring system is put in place.

SENATOR LESLIE:
One reason the sentinel events registry was created was to collect what was happening. Even though each event is different, people can see how many events and of what type they are so that people can to be trained to deal with them. That leads to why we want to let the HD use their fine money more broadly and assist the industry in training, if that is what is needed, to make sure these events do not happen again.

JOSEPH GREENWAY (Director, Center for Health Information Analysis, School of Community Health Sciences, University of Nevada, Las Vegas):
I have written testimony I will read (Exhibit C).

BOBBETTE BOND, M.P.H. (Executive Director, Nevada Health Care Policy Group, LLC):
You have been provided a copy of a document titled "SB115, BILLED CHARGES AND PATIENT IMPACT" (Exhibit D).

We support what Mr. Greenway has been working on in having the quality indicators being posted online. One of our priorities is the language mandating the indicator be based on national quality indicators and that it be continued without a new regulatory process. We believe a pass-through process where they can be posted rather than going back to regulations every time new indicators are ready would be efficient. We heard testimony from Mr. Welch in S.B. 209 about a rate versus a number. We want to make sure we understand

clearly what you mean by rate adjustment in a work group. Rates level the playing field. The numbers are important depending on the specific sentinel event coming from the registry. We would like to highlight the importance of keeping all three databases in place. The sentinel events registry is one, the National Healthcare Safety Network is the second and data generated because of A.B. No. 146 of the 74th Session is the third.

We would like to help work on the definition of "adverse health event" as well as the readmissions issue. We would like to review whether the limit of 50 top diagnoses and 50 most common diagnoses is relevant anymore. The industry and technology have moved a long way in the last four years, and the national indicator sets are really growing.

My last comment would be to mirror what Mr. Greenway said about making sure the facility level is included in all three of these databases so we can move forward on consumer notification and transparency.

BILL BRADLEY (Nevada Justice Association):
When these events occur, everybody knows what happened but the family.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The University of Nevada, Las Vegas (UNLV), Center for Health Information and Analysis (CHIA), particularly Joseph Greenway, do a great job and are an excellent resource for Nevada. Mr. Greenway does this in a cost-effective manner. The bill should be within the capacity of both the HD and UNLV, CHIA. I want to make sure if this gets expanded, Mr. Greenway has the resources he needs to make sure they continue to do a great job with the Nevada Compare Care Website.

CHAIR COPENING:
We will send S.B. 264 to a subcommittee and Senator Leslie, Senator Brower and Senator Kihuen can serve on the subcommittee. We will now open the meeting on S.B. 115.

SENATE BILL 115: Establishes provisions governing payment for the provision of certain services and care to patients and reports relating to those services and care. (BDR 40-192)

SENATOR VALERIE WIENER (Clark County Senatorial District No. 3):
Senate Bill 115 requires hospitals and physicians not contracted with patients' health insurance or health plans to accept certain rates as payment in full for certain services and care. The measure requires the health plans that receive the specified rate to review the adequacy of their provider network and review the frequency of plan members being treated at out-of-network hospitals or by out-of-network physicians and to provide adequate education to plan members regarding the plans in network hospitals and providers. This was an important concept to create consumer awareness. In addition, the measure requires that health plans submit a report regarding these reviews and educational efforts to the Legislative Committee on Health Care (LCHC). The bill revises provisions relating to the duties of the director of the Office for Consumer Health Assistance (OCHA), Office of the Governor, and requires the Commissioner of Insurance, Division of Insurance (DOI), Department of Business and Industry, to study issues relating to policies of health insurance and similar contractual agreements. In addition to other issues, the measures also require the commissioner to adopt regulations. Finally, S.B. 115 requires the LCHC to review the provisions of this act, including the rate of payments set forth in sections 13, 14 and 15 to determine whether providers of health care are being adequately compensated for services and care. Senate Concurrent Resolution No. 39 of the 75th Session prompted this issue to be included on the agenda of the LCHC. We were directed to review methods for establishing a fair and equitable system for payment of certain medical services. Specifically, the payment system address individuals who are covered by a policy of insurance or other contractual arrangement or agreement with a third party for their health-care coverage, but their insurance or contractual agreement does not cover expenses for the specific hospital or physicians that provided the service or care. Frequently, this is referred to as non-contracted, out-of-plan or out-of-network hospital or physician.

We considered the relationship between the actual costs to hospitals and physicians to provide medical services and care and the charges billed to the patient. We also considered the process used by providers of health care and health insurers and other third parties who provide coverage for the provision of health care to negotiate contracts. We considered the process for granting hospital privileges to physicians and related issues concerning contracts with health insurers and other third parties that provide coverage for the provision of health care and balance billing. That is often how this measure has been referenced throughout the work we have done on it, including work in this

Session. Balance billing and collection practices implemented by providers of health care affects the escalation of billed charges on the costs of health care. The LCHC heard testimony regarding rising health-care costs and the impact on consumers; concerns about the shifting of costs; concerns about nonpayment by patients and Medicaid payment reductions; third-party payer network adequacy concerns; differences between traditional-commercial insurance and managed-care insurance; the difference between state-licensed insurance plans and other types of contractual agreements with third-party payers; the impact of health-care professional shortages; patient education with regard to coverage; and the cost of services of care. This was extensively deliberated. Following the deliberations, the committee agreed to recommend this bill.

MARSHEILAH LYONS (Policy Analyst):
As a staff member of the Legislative Counsel Bureau, I may not advocate for any measure that comes before this body. You have a document titled Senate Bill 115, Committee on Health and Human Services on behalf of the Legislative Committee on Health Care. It has a section summary chart attached (Exhibit E).

CHAIR COPENING:
I put together a large stakeholders' group that had concerns with the bill as it is currently written. I would like to have Ms. Robbins and Mr. Ellis talk about some of the meetings they had after the stakeholder's meetings.

HELEN M. ROBBINS (Hospital Corporation of America, Sunrise Health System):
My perspective coming into this has been to maintain a balance to compel both parties to negotiate. Having an agreement is the ideal situation. If the bill is off balance, the terms by which an out-of-network provider gets reimbursed will take away some of the motivation. I have also said in these meetings that we need to stay aware that we not be too punitive when it comes to setting a regulatory environment for the providers. We have a lot of common goals about quality and improving the services we provide and improving access to Nevadans. We want to make sure we do not go so far with the bill that we dilute our other goals.

We also have common ground that we would all do better if the final result of this bill is as simple as possible.

To get this as close to fair and appropriate as possible, we have established things such as the contingencies by which an out-of-network rate would be paid, communication protocols that would need to be established and eligibility requirements about who can tap into this. The one remaining issue is the exact rate by which an out-of-network hospital might be paid for the services provided to members.

JEFF ELLIS (Vice President, Chief Financial Officer of Corporate Benefits, MGM Resorts International; Health Services Coalition):
I agree with what Ms. Robbins has said. The stakeholders' group meetings have moved us ahead. We have a solid foundation. The one issue that is still going to be difficult to overcome is what a fair reimbursement is for an out-of-network physician for the community partners that are supporting this bill, and the hospitals' expectations.

MS. JOHNSTONE:
The HSC's mission has been to work towards improving health-quality accessibility as well as affordability. Both the costs of health care and the charges for that care continue to increase dramatically and the growing discrepancy between the two is unsustainable. Between 2000 and 2007, the consumer price index increased 22 percent while the average billed charges per hospital patient in Nevada went up at 10 times that rate. There have been states, approximately ten, that have already addressed the problem in billed charges with legislation. We would not be the first in that area. One of the perceptions in the past has been that the escalation of billed charges does not matter as no one actually pays billed charges. In reality, many individuals do. Billed charges are a severe problem even for those with insurance who, by no fault of their own, end up in a non-contracted hospital. If patients are unable to control where they go for emergency care, they should not have to pay whatever the hospital charges for that care. Billed charges are also an issue in an increasingly common situation where a patient goes to an in-network hospital but is treated by a non-contracted physician working at that facility. Those who are uninsured can request a 30 percent discount off their billed charges. The billed charges often cause severe consequences even for insured patients and for health plans in Nevada, and they have distorted the health-care market beyond what can be absorbed.

We all know health care is complex. There is no single action, legislative or otherwise, that will fix patient safety, quality and the cost challenges that we

face. This legislation puts forth what we believe is a fair solution that protects Nevadans from having their financial lives destroyed by the care they had little choice in selecting. We urge the passage of this bill.

SENATOR LESLIE:
In all the years I have been here, we have had this bill every session. We need to do something this time. What is the basis for finding out the billed charges?

MS. JOHNSTONE:
That would be best answered by someone in the hospital industry.

SENATOR HARDY:
How do we determine the rate that is paid? It almost seems as if I have two secrets I am trying to negotiate—a billed charge and a rate that is paid—and I never want them to come together. I would ask the same question from a different angle.

SENATOR KIECKHEFER:
My twins were born in a hospital that was outside of my network provider. My insurance policy stated I was covered for emergency services, and my insurance paid the bills for the emergency care my twins received when they were born out of network. I decided I did not want to pay the ridiculous amounts of money to an out-of-network hospital and transferred the twins to where they were covered. Is that not how most insurances work? If I were insured by your plan, I would have been stuck with the bill, and you would not have paid the out-of-network emergency care. Is that correct?

MS. JOHNSTONE:
Emergency care would be picked up in combination by the participant as well as the plan, in most cases. After the patient is stabilized, more of the burden would be shifted to the patient. We have two scenarios going with the non-contracted hospital as well as the non-contracted physician who is in a facility that is part of the health plan. The cost is paid at the non-contracted facility by either the plan or the member at a much higher rate. That is what we are trying to address. How that cost is shared varies somewhat between the plans.

SENATOR KIECKHEFER:
Is the answer yes?

MS. JOHNSTONE:
Yes.

SENATOR KIECKHEFER:
Do most plans work like my experience?

MS. JOHNSTONE:
Yes. In your experience, even the health plan had to pay higher costs while you were at the non-contracted facility.

RUSSELL ROWE (Boyd Gaming Corp.):
Boyd Gaming Corporation is a member of the HSC and serves on its executive committee. I am here today in place of William J. Noonan, Senior Vice President, Administration. Boyd Gaming employs and provides insurance for approximately 10,000 employees in Nevada, and insures approximately 13,000 individuals including spouses, children and dependents. In total, Boyd Gaming spends $35 million to $40 million annually in Nevada on health care for its employees. Senate Bill 115 is critical to helping employers gain predictability and management over their health-care costs. While we do everything we can to insure our employees fully and provide them and their families with peace of mind, the truth is that employers can incur, through no fault of their own, charges simply because the member was taken to a non-contracted hospital or even taken to a contracted hospital but happened to be seen by a non-contracted specialist. Employees come to us for help when they receive their bill because they cannot afford to pay it and question why their insurance did not cover the care they received. We often assist our employees and negotiate a plan. These are not only our employees; they are your constituents and the backbone of our economy. Despite our best efforts to insure them, they are vulnerable to severe financial hardship as a result of this problem. This bill provides an equitable solution to billed charges. If more work needs to be done on this, Boyd Gaming will continue working on the matter. The bill is crafted narrowly to apply to Nevada insurance plans and not to tourist or out-of-state people visiting Nevada. As one of the major employers in our State, we strongly encourage your support of S.B. 115. It will provide employers with the ability to manage and budget their health-care costs better, and to protect employees from potential financial ruin. This is good public policy for Nevada, its citizens and its employers. The time has come to adopt this legislation. On behalf of our 10,000 employees, Boyd Gaming asks for your support of S.B. 115.

RUSTY MCALLISTER (Professional Firefighters of Nevada):
The bill addresses patients being taken to hospitals through no choice of their own. The health districts in both of those areas have protocols set up. These protocols are set up for things such as trauma where patients are taken by geographical location depending on the extent of the injury. There are neonatal protocols as certain facilities are better equipped to handle level-three neonatal and sexual assault patients. The hypothermic intravenous infusion therapy for patients who have suffered cardiac arrest and have been resuscitated is a new program in southern Nevada. There are only two or three hospitals to which patients can be taken. There are other situations that control where patients are taken. They can be unconscious and unable to say they cannot go there. Perhaps their conditions warrant they cannot be taken someplace else. If a patient has a severe cardiac problem, we have to take the patient to the closest available facility. We cannot bypass a facility to go to a covered hospital. If we do and something happens, we have stepped outside the bounds of our skill set and would be subject to liability. I am the chairman of the Professional Firefighters Health Insurance Trust Fund which serves about 2,100 people. Not knowing what will happen has a big impact on our trust fund. Someone may be taken to a hospital that is a provider with us; however, within that facility there are physicians who are not providers.

SENATOR BROWER:
If I understand this correctly, the hospital bill will be paid if someone goes to an out-of-network hospital because of an emergency.

MR. MCALLISTER:
If a member is taken to a facility that is outside our network, we pay a certain percentage. The member can apply for an appeal.

SENATOR BROWER:
It sounds as if the providers pay more if an insured is taken by way of an emergency to an out-of-network provider, and the insured does not pay more.

MR. MCALLISTER:
Are you asking if the person taken to the hospital pays more out-of-pocket fees?

SENATOR BROWER:
Yes. In an emergency situation such as Senator Kieckhefer experienced, he may not be forced to pay a higher amount, but his insurer may have.

MR. MCALLISTER:
If you are taken to a covered hospital for emergency treatment, the rates have been set for that place. We know what the negotiated rates would be. If you are taken to a non-covered facility, that rate is not a negotiated rate anymore. Instead of a bill for $10,000 that is split 20 percent and 80 percent, there maybe a bill that is $30,000 that is split 20 percent and 80 percent.

SENATOR BROWER:
Is this a consumer problem or is it a problem for the plans?

MR. MCALLISTER:
I would say both.

MR. WELCH:
Nevada Revised Statute (NRS) 449.490 only enables us to have one charge master. We cannot have a different charge master for everybody. I have to set my charges at a level so I can recoup sufficient revenues to cover my operating costs. For the hospitals, 69 percent of our business is legislated as to what can be reimbursed through Medicare or Medicaid. That leaves 31 percent of our patients from which we have the ability to try to recoup our operating costs. If we can only have one charge master, the amounts in the charge master begin to escalate. If all payers paid costs or a level that approximates costs, that charge master would look significantly different.

CHRISTINE BOSSE (Renown Health):
From a basic perspective, the facility would start with the cost for a supply item; then there is a markup schedule for the supply items. If they are procedure or treatment based, estimates for the labor along with the actual supply costs and the cost of equipment are included. Over time, charge masters can get skewed because of the need to increase the charges each year to be able to collect enough to cover our costs.

SENATOR LESLIE:
Can you remind me what we did on the charge master?

MR. WELCH:
The charge master was through your legislation in 2007. We are required to make that charge master available through the HD. Any patient who would like to have access to the charge master has that ability.

SENATOR LESLIE:
Why is it that hospitals cannot require doctors to address this problem? If they work in your hospitals, can you not control the doctors?

MR. WELCH:
All hospitals have credentialed physicians who provide clinical services for patients within their facilities. Our credentialing process is to ensure they are properly trained and continue their education, and that they are skilled to perform the functions we are authorizing them to do. However, they are independent practitioners who bill for their services separately. Because they are independent contractors, we have no control over them.

SENATOR LESLIE:
What we are doing starts when the patient is stabilized. What about the emergency?

MR. WELCH:
That is the same answer.

SENATOR KIECKHEFER:
Do the same rules apply for public hospitals and private hospitals? Why is the University Medical Center (UMC) not included in this bill?

MR. WELCH:
All hospitals, regardless of whether they are private or public, are regulated by the same laws that govern the charge-master requirements. I would have to ask the sponsor to explain why UMC would not be included in this bill. They are the only level I trauma center in the State. They would likely get a significant number of patients being transported as a result of the protocols described in previous testimony. Hospitals do not control the patients who come in. The protocols that direct emergency medical services (EMS) are based on national and state standards. When an ambulance picks up a patient and transports that patient, it not only has to comply with the local county and health district emergency medical technicians (EMTs) jurisdiction, but they also have to follow EMS protocols.

CHAIR COPENING:
Because UMC is the safety-net hospital, they were not included in this particular bill.

SENATOR KIECKHEFER:
Do they not follow the same procedure for billed charges? It seems that creates the same problem.

CHAIR COPENING:
We do not remember it entirely. We can go back through the minutes and find out why we arrived at that.

MR. WELCH:
A number of hospitals in the communities are also trauma centers based upon their geographic locations. We are not trying to talk UMC into the bill. We are trying to understand why they are not in the bill. They are a very important part of our health-care delivery system.

JAMES WADHAMS (Nevada Hospital Association):
I would like to comment on a point that Senator Leslie asked. There is what is called a "corporate practice" of medicine. There is a series of opinions of the Attorney General and the Legislative Counsel Bureau regarding whether or not hospitals can employ physicians. Historically, that has been prohibited. The general theory is the clinical expertise of the physician cannot be encroached upon by a layperson. A hospital executive cannot issue orders to a physician or a nurse. The exception that has been developed in the Attorney General Opinions is that UMC as a county hospital is not a person. The county is not a person under the statute, and therefore, this is not employment by another person.

SENATOR LESLIE:
When we did the health-care costs containment, was the charge master regulated during that time period so that it could only grow so much at a time?

MR. WELCH:
Yes. We did have rate controls throughout the 1990s.

SENATOR LESLIE:
Do we still do it?

MR. WELCH:
It had a sunset for 1999.

CHRIS COLLINS (Las Vegas Police Protective Association):
I represent approximately 4,500 men and women in law enforcement and their families. The Las Vegas Police Protective Association is in support of this bill. In an effort to not be repetitive, I will let Mr. Reid convey my thoughts.

MS. BOND:
The loss of any regulations on billed charges had some of the impact on why we are here. There is a handout about billed charges and patient impact (Exhibit D). The situation with Senator Kieckhefer's twins is exactly the situation this bill is trying to address. There is an impact on both the plan and the patient. In most plans, patients are not covered 100 percent with billed charges. There is a bill to the patient that exceeds what they expected. The difference between what happens at a contracted rate and what happens at the billed-charges rate is what is unsustainable. There was a lot of discussion in the last Legislative Session about why UMC should or should not be in the bill. I think the intent was because they are exempted in NRS 439 across the board. They are completely taxpayer supported. The taxpayers pay the bottom line for anything that happens in that hospital, and that is not true anywhere else. The hospitals cannot provide an assurance that care is going to be provided in the hospital and that doctors will be contracted. It is a situation where no matter what is the hospital contract, the patient has no idea when getting to the hospital if their doctors are going to be contracted or not. I am not sure how Senator Kieckhefer knew what his bill was so he could get his family transported out of the facility. Most people do not know what those charges are until they are done with their entire hospital stay. I am hopeful that the stakeholders' group is hearing a commitment on our part as the insureds and the insured policyholders to make sure we do a good job in getting people out of the hospital they are not contracted with.

It is my understanding that the charge-master charges can change at any time. I do not know if that is true or not. We should verify that with Mr. Welch. There has never been a clear understanding of how the charge master is set and how often it can change. The fact that it is accessible to patients if they ask for it does not help them understand it. We would like to have that publicly posted in a way that patients can understand. We also do not understand the physician charges and how patients find out what the charge is for the doctor. We do not know how that is set, how often it changes or what it is based on.

In Nevada, we started strictly regulating billed charges in 1997. When the caps where lifted, they climbed fast along with billed charges. We were told at that time the capping of billed charges was not a good solution. Our trend on billed charges flattened out while there were caps in place, and that reduced the trend on billed-charges escalation. No one was paying attention to it, and it sunsetted.

SENATOR HARDY:
Physicians are not allowed to tell other people what they charge, or they will go to jail. People who are admitted to a hospital are almost immediately assigned a case manager who tries to get you out of the hospital. We have a lot of laws that preclude the physician from doing things that would make this simpler. When a person goes into a hospital, I cannot transfer that person to another hospital unless the patient develops the need for a higher level of care. The federal law precludes some transfers from happening.

SENATOR LESLIE:
I would have to guess at which hospital I have. How do you educate the people you are covering?

MS. BOND:
I work with the Culinary Health Fund the most, and we have approximately 50,000 covered members. There are different techniques to make sure people understand the network design. We have a Website that has a directory of all our providers, and a place to call to find that out. We feel that in most situations, it is our responsibility and the member's responsibility to understand the network and their plan design. However, in an emergency situation, members may not have a choice. We still have better control in that situation than we do when someone goes to a contracted facility and has a non-contracted doctor. There does not seem to be a systematic way of knowing who are the contracted doctors in a facility. There is a case manager in the hospitals trying to make sure the patient gets the care needed and gets released from the hospital as soon as possible. However, I do not believe those case managers discuss the cost impact with the patients. The patients are completely unaware of the charges from the time they get to the hospital until the time they get out.

CHAIR COPENING:
Section 15 deals with a "not an emergency" situation, where an out-of-network physician in an in-network hospital provides medical services and care for

reasons other than to stabilize the patient. I want to make sure we know we are talking about more than just emergency care in this bill. That would be a situation where someone may have a scheduled surgery, but an out-of-network anesthesiologist assists in that surgery. As it stands now in the bill, those physicians would be subject to the provisions of this bill.

MS. BOND:
I was not aware of that issue until two days ago. It was my understanding this bill was restricted to hospital activity based on an ambulance transport.

SENATOR KIECKHEFER:
Why is it in the insurance product that you provide to your members you do not cover emergency care out of network? Is it cost prohibitive? What factor would drive up the premiums you charge your members?

MS. BOND:
There is no limit on billed charges. We cannot account for how often it is going to happen, or how much it is going to cost. It is covered if it is an out-of-area emergency, but there is a higher cost share for the patient. Most plans have that. The nonprofit plans have the patient appeal for that care when it was a true emergency. The appeal gets paid by the fund. I do not think that is true in the commercial insurance market.

SENATOR KIECKHEFER:
Where is the commercial insurance market on the bill? I have not seen any testimony submitted.

JACK KIM (United Healthcare Services, Inc.):
The commercial market is governed by DOI. We have rules in place on out-of-network care and on emergency coverage. In 1997, a state-managed care or a “patient’s bill of rights” required us to pay for emergency coverage in these settings. When we have plans that end up in these settings, we pay for the billed charges. We did see an escalation of those billed charges from 1999 to 2001, when the hospital containment laws sunsetted. We first brought the bill in 2001 to address the issue. This bill is more expansive than what we envisioned back then. In the self-funded plan, they are not paying what we would consider premiums. They are paying this out of their funds. For them, it is one direct cost. We build that into our premiums which are paid by all the employers and individuals who buy our products.

SENATOR HARDY:
Have you figured out what the premium needs to be to for your billed charges?

MR. KIM:
I am not the one who can answer that question. I do know when we seek trends like this; we put those trends into rate filings. It depends on the number of hospitals we have in contract, the number of members, the number of billed charges and what we anticipate those billed charges are going to be. We do put that into our memorandums and filings. The difference between us and a number of the self-funded plans is that we have people on staff who can look at the data and trends nationwide.

SENATOR HARDY:
Do you know if the self-funded plans are not in a position to petition us to be under the insurance commissioner?

MR. KIM:
I will have to let them answer that question.

MS. BOND:
The self-funded plans are not for profit. They operate on a slimmer margin. They are put at more risk by the volatility of these spikes that billed charges represent. If there are enough spikes, it will put plans at risk, and we will be reduced to the commercial market. The self-funded plans feel they need to be treated differently. They exist for a different reason. They are not returning profits to shareholders. They are here in the community and reinvest everything back into the community. They are serving the interest of the participant 100 percent of the time.

SENATOR HARDY:
Is there one that is allowed to look at the reinsurance market or buy the premium with the self-insurance insurance for the *quasi* insurance that self-funded plan gives?

MS. BOND:
Yes. We have the ability to buy reinsurance, but the reinsurance market is based on experience. We will pay as much for reinsurance as we will for billed charges.

SENATOR HARDY:
Does that not let you anticipate your charges?

MS. BOND:
It does, but it does not help us afford them.

SENATOR BROWER:
Would the typical insured in a self-funded plan not have his or her emergency bills paid by the plan in the same way that an in-network emergency situation would be paid? Did Senator Kieckhefer get lucky? I do not know what hospital in Reno is in my plan. I am also assuming that if I have an emergency in Las Vegas and to go an out-of-network hospital, my bill is going to be paid just as though I went to my in-network hospital.

MS. BOND:
We do have a higher cost share when a participant goes out of area for an emergency. It is covered, but the participant has a higher cost share. That is all changing with health-care reform, and it is being included in the bill as proposed now. The patient would not be paying a higher cost share for an emergency than they would for any other kind of care. I do not know if Senator Kieckhefer was lucky or if that is the standard with commercial insurance. We have a lot of doctors who do not want to be contracted at all. In the hospital setting, it is easy for them to do, because they can just get billed charges. They can charge what they want to charge. They are going to see those patients anyway in the emergency room.

SENATOR BROWER:
Is the typical insured in a self-funded plan paying premiums every month? There are some insureds in some self-funded plans that do not pay premiums. It is a perk of the job. Is that common?

MS. BOND:
I can speak to the Culinary Health plan. The trust fund is funded by the contracted-negotiated rates. The employer then pays for an hourly rate for every employee they have. That rate goes into the trust fund, and the bills are paid based on that rate. Some trust funds have a patient premium and some trust funds do not. Ours does not.

SENATOR BROWER:
Does your typical culinary employee pay a premium?

MS. BOND:
No. The Culinary Health Plan has made a very strong stand over many years to trade almost anything else to protect people's insurance.

SENATOR BROWER:
I have a good friend who is a bell captain in Las Vegas. My impression is that he does not pay a health-insurance premium. Is that typical of employees covered by the Culinary Health plan?

MS. BOND:
That is the Culinary Health plan.

SENATOR BROWER:
Is there no premium being paid by the employee?

MS. BOND:
To clarify, if they do not make enough hours to pay, then they have the opportunity to self-pay the amount they did not work. A substantial portion of our population is contributing a cost share to keep their insurance.

THOMAS REID (Assistant Executive Director, Las Vegas Police Protective Association):
I have a prepared testimony I will read (Exhibit F).

CYNTHIA KISER MURPHEY (President, Chief Operating Officer, New York-New York):
I am the Chief Operating Officer of New York-New York, which means I represent MGM Resorts International and our 50,000 employees and their families in Nevada. I also chair and serve on the Board of Directors of the HSC. I served in human resources for 20 years in Nevada and have handled many negotiations. We need to partner with our hospitals and spend time working on programs to improve quality. We understand that for them to provide the vital services they do, they need to be financially solid, as do all of our organizations. We also have to protect our individual numbers from these catastrophic consequences. Many questions have been asked about why we do not just pay the billed charges. We do not have any control over those billed charges.

Health-care dollars are limited in all economies, but particularly now. If we have to spend more dollars on this, we do not have the dollars to then pay other parts of the health plan. We need to be fiscal agents to represent our people as we put our health plans together. You have heard from many of the experts on the technical aspects of the bill. I want to point out a couple of other points that amplify what has been discussed already. This bill is narrow. In prior years, one of the reasons it was not successful is that it was broader. The HSC and MGM Resorts believe that the restriction for this to apply to patients who are transported by ambulance is a very small fraction of the number of patients who actually visit the emergency room. It does not apply to patients who access non-contracted facilities or doctors for nonurgent reasons. It does not apply to patients who can be transferred to a contracted facility. It focuses narrowly on the care when patients do not have control over the facility they have been sent to or the doctor they are seeing.

SENATOR HARDY:
How can someone take a percentage of anything when they do not know what the percentage is? That is one of the challenges we have. In the medical profession, we do not know your contracted rate. How can doctors decide what they are willing to take?

MS. MURPHEY:
In the mechanics of the bill, there is a method of calculating that and a method of finding an early resolution. We talked with the physicians who attended our stakeholders' meeting in trying to provide fair, reasonable and transparent methods to do that. We are open to ideas and finding reasonable solutions to compensating the physicians.

MR. ELLIS:
I have written testimony that I will read (Exhibit G).

One of the issues we talked about in our stakeholders' group meetings was establishing a usual and customary rate by specialty and by physician for our community, for our community partners and for the physicians, so they know exactly what those rates are. We will pay them a premium above that. I have volunteered to canvas and understand what the average rates are for the contracted physicians in all of the different specialties in our community. We are willing to put some rates forward.

I would like to explain what the impact is to the employers and employees regarding the emergency issues. Most plans will pay in-network benefits to an individual who comes into a hospital on an emergency. If it is an out-of-network and a non-contracted provider, our employees' plan is structured so that our employees do not "max out" of their out-of-pocket obligation. At in-network facilities, they do. An in-network facility might say the maximum out-of-pocket for the year is going to be $2,500. At an out-of-network facility it is unlimited. That is compounded by the fact that the bill we get from an out-of-network provider could be five or six times the amount we would pay an in-network provider. The cost of that impacts our health plan and our ability to continue to provide quality, cost-effective care to our employees and impacts them to an extent beyond what they should be in a normal insurance situation. This bill is trying to center on an emergency transport to a facility that may be non-contracted. We are not saying we want to pay a contracted rate. What we have been discussing is how far above the contracted rates or how low below billed charges are we willing to pay. We are not expecting a free handout from these facilities. We would like to regulate what that rate is going to be in the future. We have just finished negotiating all of the hospital rates. What their demands are from a rate perspective can vary tremendously. There could come a point in time when we as a community cannot have every hospital under contract. The commercial insurance companies have already gone through this situation. We chose, in the self-funded industry, to keep our costs down to be able to regulate what we pay. Part of that is in situations where either a physician or a hospital chooses not to contract with us or the rates they demand are so high we can no longer afford to contract with them. We are just asking that in situations where we have no control, there be some limit as to what is our ultimate liability.

DAVID A. SILVERBERG, M.D. (Vice President, Nevada Orthopaedic Society):
I have written testimony which I will read (Exhibit H).

MARILYN G. WILLS (Interim Director, Bureau for Hospital Patients, Office for Consumer Health Assistance, Office of the Governor):
I am here to testify on S.B. 115 and have given you a copy of written testimony (Exhibit I). Our office was asked in the legislation to be a mediator between the health plans and providers of health care in determining fair and reasonable payments for emergent care. We have researched and mediated these kinds of complaints for a long time. We have researched an initial process for the mediation. We suggest a process similar to the external review and the use of

an outside entity if we were unable to negotiate a settlement. That would most likely be the Hearings Division, Department of Administration, where the staff is qualified and already has a set fee in place. If we were to fail in our negotiations with the provider and the insurance company, we would forward that to a hearing officer at the request of one or both parties. The information would be processed to the hearing officer from both parties along with our written recommendation. The determination from the hearing officer would be final, and costs of that would be borne by the requesting party.

As you know, our office is available statewide to consumers. We are a small organization and only have three specialists and one hospital specialist. Since 2008 to March 2011, we have handled almost 600 cases of balance billing. In most cases, balance billing put the consumer in medical bankruptcy. We handle cases that are not only self-funded but also commercial market cases. We have had 33 cases alone for one particular provider since 2009. Sometimes their charges are 900 percent of the Medicare-allowed charges. We were frustrated enough in not being able to negotiate with that provider that we turned it over to the Attorney General for legal action. We consider this a significant problem in the State.

LAWRENCE P. MATHEIS (Nevada State Medical Association):
We oppose S.B. 115 as it is introduced. We all know this is not the bill you will be processing and that the proponents did not know exactly what the bill had in some key parts. Since the proponents have all been from self-funded plans, they have one perspective. The physician community, depending on the specialty, has a different perspective; the hospital community has a different one; and commercial insurers have a different one. One of our concerns is it will be a windfall profit for those insurers who do not deserve it, because they have inadequate panels run for profit. If you do not have those high-end specialties in the right numbers on your panel, the cost passes to the patient. That is why the adequacy of the network study is essential. It is not essential with the self-funded plans. It is essential if it, as S.B. 115 does, includes all commercial and private insurers. There are some that have policies that run inadequate panels as a way of keeping more of the premium dollar and passing excessive cost to the patients. Not all the plans actually have directories of the panels that are up to date and available to their patients. Sometimes the directories of a provider network have dead providers on them—not recently deceased but dead for a significant amount of time; they should have been noticed. For marketing purposes, the facility wants to look like there is more specialty than they have.

Those are real issues. Fundamentally, we have done a great disservice to the health-care system and a great disservice to ourselves as potential patients in how we have redefined the role of the emergency department over the last generation. It is the catch-all for every failure in the health-care system. People who are uninsured go there for primary care. If we do not have enough mental health beds, they will end up on a psychiatric hold in the emergency department for four or five days until a place can be found.

These are about private contracts privately decided. For the protection of the ability to have private contracts, one also has to protect the ability not to contract. Otherwise, it is a meaningless right. When the government weighs in on trying to balance the scales regarding contracts, it has to be very careful not to create an imbalance that causes unanticipated results. The other is that self-funded plans are preempted for the most part from State law. During the interim, we submitted a letter from the legal team at the American Medical Association, which has been involved in a number of the national contests about the Employee Retirement Income Security Act of 1974. Whenever we testify during the interim, we try to come up with specific ways around a problem we identified. Nevada cannot regulate the self-insured plans. However, the plans can agree to an arbitration or mediation process. Texas had a similar issue where the proponents tried to do something about balance billing issues in a self-funded plan—their state employees' plan. We think it is not clear enough that it is really an arbitration model rather than a cap model, but the working group is on the right track in trying to deal with those situations where the patients have no discretion.

The other thing that S.B. 115 needs to do is sharpen the definitions and make sure they are consistent with the national definitions.

BRET W. FREY, M.D. (President-Elect, Nevada American College of Emergency Physicians):
I have written testimony that I will read (Exhibit J).

MS. LYONS:
In section 14, subsection 1, the bill reads "Except as otherwise provided in this section, an out-of-network physician on the medical staff of an out-of-network hospital with 100 or more beds shall accept as payment in full for the provision of emergency services ... ". Section 15, subsection 1 states "Except as otherwise provided in subsections 3 and 4, an out–of-network physician on the

medical staff of an in-network hospital with 100 or more beds shall accept as payment in full for the provision of medical services and care to a patient, other than services and care provided to stabilize the patient, ..." The services and care provided to stabilize the patient would not be subject to this rate.

DR. FREY:
The bill in its current language is at odds with itself in respect to its definitions. On one side it says emergency care is going to be in the mix. Then it says care provided to stabilize the patient is not.

CHAIR COPENING:
We will consider that and make sure the intent is consistent.

SENATOR HARDY:
The caveat there is the 100-bed hospital.

KAREN MASSEY (Chief Administrative Officer, Northern Nevada Emergency Physicians):
I came forward to see if I can offer any technical response to some of the questions about physician payment. Given the late hour, I am happy to do that another time.

CHAIR COPENING:
Please make sure that we have your card and information, and we will get back to you.

SUSAN FISHER (Nevada Anesthesia Patient Safety Pac):
The Nevada Anesthesia Patient Safety Pac is opposed to this bill in its current form. This bill is about contracting and not about predatory billing. The arbitration panel solution solves the problem of predatory billing to everyone's satisfaction without contracting. We approve of some of the things that Mr. Matheis mentioned about Texas. This is one of the more important pieces of legislation about the medical community in the last decade. We agree that inappropriate balance billing should be discouraged, but the passage of this legislation, as written, would be a disincentive to Nevada payers from contracting in good faith with the providers. I have provided a proposed amendment (Exhibit K). We provided some other options during the meetings you have had with the stakeholders' group.

CHAIR COPENING:
Anybody who has proposed amendments will need to have them to us by close of business on Tuesday, March 29, 2011. We will schedule a work session then.

MR. DUARTE:
We are neutral on this bill but have concerns. Our written testimony and comments missed the mark in terms of the intent of the legislation. I would rather just speak on the issues and will request an amendment to exempt Medicaid and Nevada Check Up from this bill. I understand this bill is to protect consumers and patients from out-of-network balance billing. The protections already exist for Medicaid and Nevada Check Up participants through federal law and state regulation. Senate Bill 115 provides for a mediation and arbitration process in sections 13, 14 and 15 that not only duplicate but potentially conflict with federal Medicaid rules around appeals. We have a very rigorous appeals process which allows providers to appeal a situation where they do not believe they were reimbursed fairly. The appeal is limited not to what we pay but to the scope of services we paid for. For example, if a hospital admits a patient and the provider disagrees with the length of stay we approved and wants to submit additional information, we will accept that appeal. Our rates are defined in the State plan for Medicaid and Nevada Check Up. Those rates are a contract between the federal government and the State. They are not subject to negotiation. We are concerned that the appeals process leaves open the possibility for the perception by the providers that they would somehow go through this appeal process and be paid something other than what we pay. There are significant conflicts with federal Medicaid rules. Because Nevada Check Up follows those rules very closely, we would like to request an amendment which you have been provided (Exhibit L). The amendment exempts our two programs. We would like to be exempt from the provisions of sections 1 through 22 inclusive for both Medicaid and Nevada Check Up. We would also request that we be exempt from the provisions of this bill as it applies to the health maintenance organizations (HMOs) we contract with. The rates we pay those providers are actuarially established and approved by federal centers for Medicaid and Medicare services. To put them in a situation where we define and actuarially certify and have a federally approved capitation rate for the HMO and then force them to pay more through an arbitration process would not be reasonable for the HMO.

SENATOR HARDY:
Do you think you will have more appeals if this should pass?

MR. DUARTE:
We believe that is correct. However, we have not put a fiscal note on it. If providers and recipients exhaust that appeals process, they have access to the courts.

SENATOR HARDY:
If you are exempting out for that reason, then other people will be caught in the same snare with mediation and potential court costs.

MR. DUARTE:
I cannot address that. I only know that we have protections already in place. The Committee may want to take a close look at the Medicare rules around balance billing. There are already some protections in place for Medicare participants that could be in conflict with some of the provisions.

SENATOR HARDY:
Are you saying that if I carve out a special rate for someone, I will get into trouble with the federal government, because I did not offer that rate for the Medicare patient?

MR. DUARTE:
I cannot speak to that. My only point here is there are existing protections in place for the Medicaid and Nevada Check Up populations that address the concerns that are intended to be addressed by this bill.

SENATOR HARDY:
If, as a physician, I offer a special deal to someone and I do not offer that special deal to everyone, I am in violation of Medicare rules. Now it becomes a little more problematic for a physician to give someone a deal and not give it to everyone, including all of my Medicare patients.

SENATOR LESLIE:
Did you say Medicaid does not allow balance billing for doctors or hospitals?

MR. DUARTE:
There is a method and procedure that can be used for a non-contracted provider to be able to balance bill a patient. However, the procedure is fairly detailed and requires that the physician or other provider talk to the patient and provide the patient something in writing that stipulates that seeing this particular provider and receiving services results in an individual situation with respect to payment. If the patient agrees and signs an agreement for the physician to balance bill, then it is allowed. However, we do not pay billed charges.

SENATOR LESLIE:
In an emergency situation the process that you just described would likely not occur.

MR. DUARTE:
Correct. I am talking more about elective procedures when someone may want to go to a particular provider who is not contracted with Medicaid.

SENATOR WIENER:
The HMO providers you are speaking about do not provide only to your program. Is that correct?

MR. DUARTE:
Our HMOs do have commercial contracts. What we are requesting just applies to those contracts they have with Medicaid and the Nevada Check Up.

KIMBERLY K. EVERETT, CPM (Assistant Chief, Life and Health Section, Division of Insurance, Department of Business and Industry):
The DI is neutral on the bill. We do have a fiscal note attached to the bill. We would like to be part of any discussions to remedy the fiscal note and make it disappear. Currently, it is the State Board of Health, HD, DHHS, that determines the adequacy of networks. They also develop the criteria for those standards of the adequacy. The commissioner has no regulatory authority over hospitals or physicians and currently is not staffed with the expertise to perform these functions to determine whether or not the networks are adequate and that the standards have been met. If the DOI were to assume these responsibilities as set forth in S.B. 115, we would have to employ at least three full-time employees. These employees would be registered nurses or some other certified professionals who have the expertise to determine that. We would encourage

the Committee to consider keeping that function with the State Board of Health and not move it to the DOI.

CHAIR COPENING:
With no further business to come before this Committee, we will adjourn this meeting at 6:42 p.m.

RESPECTFULLY SUBMITTED:

_____
Shauna Kirk,
Committee Secretary

APPROVED BY:

_____
Senator Allison Copening, Chair

DATE:_____

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A	Agenda	Agenda
	B	Attendance Roster	Attendance Roster
S.B. 264	C	Joseph Greenway	Written testimony
S.B. 115	D	Bobbette Bond	SB115 BILLED CHARGES AND PATIENT IMPACT
S.B. 115	E	Legislative Committee on Health Care	Summary
S.B. 115	F	Thomas Reid	Written testimony
S.B. 115	G	Jeff Ellis	Written testimony
S.B. 115	H	David A. Silverberg, M.D.	Written testimony
S.B. 115	I	Marilyn G. Wills	Written testimony
S.B. 115	J	Bret W. Frey, M.D.	Written testimony
S.B. 115	K	Susan Fisher	Proposed amendment
S.B. 115	L	Charles Duarte	Proposed amendment