



Senate

General Assembly

File No. 700

January Session, 2015

Substitute Senate Bill No. 815

Senate, April 16, 2015

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING A COMMISSION ON HEALTH CARE POLICY, COST CONTAINMENT AND PRICE VARIATION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2015*) (a) As used in this
2 section:

3 (1) "Accountable care organization" or "ACO" means an
4 organization of clinically integrated health care providers;

5 (2) "Health insurance carrier" means any insurer, health care center,
6 hospital service corporation, medical service corporation or other
7 entity delivering, issuing for delivery, renewing, amending or
8 continuing any individual or group health insurance policy in this
9 state providing coverage of the type specified in subdivisions (1), (2),
10 (4), (11) and (12) of section 38a-469 of the general statutes;

11 (3) "Health care provider" means any person, corporation, facility or
12 institution licensed by this state to provide health care services; and

13 (4) "Provider organization" means a corporation, partnership,
14 business trust, association or organized group of persons that is in the
15 business of health care delivery or management, whether or not
16 incorporated, that represents one or more health care providers in
17 contracting with health insurance carriers for the payments of health
18 care services, including, but not limited to, a physician organization,
19 independent practice association, provider network or accountable
20 care organization.

21 (b) There is established a Commission on Health Care Policy and
22 Cost Containment, as an independent administrative commission that
23 is not subject to the supervision or control of any other executive
24 officer or agency. The commission shall be governed by a board of
25 directors consisting of the following members:

26 (1) One appointed by the speaker of the House of Representatives,
27 who shall have demonstrated expertise in health care consumer
28 advocacy;

29 (2) One appointed by the president pro tempore of the Senate, who
30 shall have demonstrated expertise in health care delivery or health
31 care management at a senior level;

32 (3) One appointed by the majority leader of the House of
33 Representatives, who shall have expertise as an institutional purchaser
34 of health insurance or health care services;

35 (4) One appointed by the majority leader of the Senate, who shall
36 have expertise in behavioral health and behavioral health
37 reimbursement systems;

38 (5) One appointed by the minority leader of the House of
39 Representatives, who shall have demonstrated expertise in health plan
40 administration and finance, including payment methodologies;

41 (6) One appointed by the minority leader of the Senate, who shall
42 have demonstrated expertise in the development and utilization of
43 innovative medical technologies and treatments for patient care;

44 (7) One appointed by the House chairperson of the joint standing
45 committee of the General Assembly having cognizance of matters
46 relating to public health, who shall be a primary care physician;

47 (8) One appointed by the Senate chairperson of the joint standing
48 committee of the General Assembly having cognizance of matters
49 relating to public health, who shall have expertise in representing the
50 health care workforce as a leader in a labor organization;

51 (9) One appointed by the House ranking member of the joint
52 standing committee of the General Assembly having cognizance of
53 matters relating to public health, who shall be a health economist;

54 (10) One appointed by the Senate ranking member of the joint
55 standing committee of the General Assembly having cognizance of
56 matters relating to public health, who shall have expertise as a
57 purchaser of health insurance representing business management or
58 health benefits administration;

59 (11) The commissioners of Public Health, Social Services and the
60 Insurance Commissioner, or the commissioners' designees as ex-
61 officio, nonvoting members; and

62 (12) The Healthcare Advocate, or the Healthcare Advocate's
63 designee as an ex-officio, nonvoting member.

64 (c) (1) Initially, the members who have expertise in health care
65 delivery or health care management at a senior level, behavioral health
66 and behavioral health reimbursement systems and health plan
67 administration and finance shall serve for five years and until their
68 successors are appointed. The members who have demonstrated
69 expertise in health care consumer advocacy, have demonstrated
70 expertise in the development and utilization of innovative medical
71 technologies and treatments for patient care, a primary care physician,
72 have expertise in representing the health care workforce as a leader in
73 a labor organization, a health economist, and have expertise as a
74 purchaser of health insurance representing business management or

75 health benefits administration shall serve for a term of three years and
76 until their successors are appointed.

77 (2) All appointments to full terms subsequent to the initial
78 appointments shall be for three years. Vacancies shall be filled for the
79 expiration of the term of the member being replaced in the same
80 manner as original appointments. Members shall be eligible for
81 reappointment under the same conditions as are applicable to initial
82 appointments. The board shall elect annually one of its members as a
83 chairperson and one as a vice chairperson. Members of the board shall
84 receive no compensation but shall be reimbursed for their actual
85 expenses incurred in service on the board. The board shall meet at least
86 quarterly and more often as its duties require, upon the request of any
87 two members and shall meet at least once each year with those persons
88 and groups that are affected by board policies and procedures. A
89 majority of the board members shall constitute a quorum. A majority
90 vote of a quorum shall be required for any official action of the board.
91 Any tie vote shall be decided by the chairperson of the board. The
92 board shall adopt its own rules for the conduct of its meetings.

93 (d) The board shall appoint an executive director. The executive
94 director shall not be required to obtain the approval of any other
95 executive agency in connection with the appointment of employees
96 and may establish personnel policies and regulations for the officers
97 and employees of the commission. The executive director shall
98 supervise the administrative affairs and general management and
99 operations of the commission.

100 (e) The duties and responsibilities of the commission shall include:

- 101 (1) Setting health care cost growth goals for the state;
- 102 (2) Enhancing the transparency of provider organizations;
- 103 (3) Monitoring the development of ACOs and medical homes;
- 104 (4) Monitoring the adoption of alternative payment methodologies;

105 (5) Fostering innovative health care delivery and payment models
106 that lower health care cost growth while improving the quality of
107 patient care;

108 (6) Monitoring and reviewing the impact of changes within the
109 health care marketplace;

110 (7) Protecting patient access to necessary health care services;

111 (8) Reviewing variation in prices and insurance reimbursement
112 rates among health care providers, by payer and provider type, that
113 shall include, but need not be limited to, (A) identifying factors
114 contributing to such price and reimbursement variation, (B) assessing
115 the impact of such variation on health care costs, insurance premiums,
116 safety net providers and access to care, and (C) recommending policy
117 changes to reduce provider price variations that are found to be
118 unrelated to actual cost or quality differences or that unnecessarily
119 contribute to health care cost inflation;

120 (9) Holding public hearings not less than annually to examine health
121 care provider, provider organization and health insurance carrier
122 costs, prices and cost trends with particular attention to factors that
123 contribute to cost growth within the state's health care system;

124 (10) Establishing annual health care cost growth benchmarks for the
125 average growth in total health care expenditures for the next calendar
126 year and publishing such benchmarks on an Internet web site
127 maintained by the commission;

128 (11) Establishing procedures to assist health care providers that
129 exceed such health care cost growth benchmarks to improve efficiency
130 and reduce cost growth, including procedures for such health care
131 providers to implement performance improvement plans;

132 (12) Providing written notice to any health care provider that
133 exceeds such health care cost growth benchmark and assisting each
134 such health care entity with the implementation of a performance
135 improvement plan;

136 (13) Developing and administering a registration program for health
137 care providers and provider organizations that shall require each
138 health care provider and provider organization in the state to register
139 under the program or be prohibited from negotiating a network
140 contract with a health insurance carrier or third-party administrator;

141 (14) Requiring registered provider organizations to report such data
142 as it considers necessary in order to better protect the public's interest
143 in monitoring the financial conditions, organizational structure,
144 business practices and market share of each registered provider
145 organization;

146 (15) Reviewing and commenting on all capital expenditure projects
147 requiring a certificate of need pursuant to chapter 368z of the general
148 statutes;

149 (16) Collecting and analyzing such data as it considers necessary to
150 monitor the financial conditions of acute care hospitals, including, but
151 not limited to, (A) gross and net patient service revenues, (B) sources
152 of hospital revenue, (C) trends in the availability and utilization of
153 health care services provided by hospitals, nursing homes and
154 outpatient clinics, (D) total payroll as a percentage of operating
155 expenses and other salary and benefit information, and (E) other
156 relevant measures of financial health or distress of health care facilities;

157 (17) Ensuring the uniform reporting of revenues, charges, costs,
158 prices and utilization of health care services and other data as the
159 commission may require to analyze changes in (A) health insurance
160 premium levels, (B) benefits and cost-sharing in health insurance
161 plans, (C) measures of health insurance plan cost and utilization, and
162 (D) payment methods;

163 (18) Entering into such contractual agreements, in accordance with
164 established procedures, as may be necessary to carry out the
165 provisions of this section; and

166 (19) Taking any other action necessary to carry out the provisions of

167 this section.

168 (f) (1) The board may request any (A) office, department, board,
169 commission or other agency of the state, or (B) health care provider,
170 health insurance carrier or provider organization to supply such
171 reports, information and assistance as may be necessary or appropriate
172 in order to carry out the commission's duties and responsibilities.

173 (2) The board shall consult with the Insurance Commissioner,
174 Commissioner of Public Health and the Connecticut Insurance
175 Exchange to avoid duplicative reporting requirements and to
176 consolidate and simplify such requirements as appropriate.

177 (g) (1) Each health care provider and provider organization shall,
178 before making any material change to its operations or governance
179 structure submit written notice to the commission. Upon the
180 commission's request, each health care provider and provider
181 organization submitting such notice shall submit information
182 concerning such change as is necessary, as determined in the
183 commission's discretion, for the commission to determine whether
184 such change is likely to result in a significant impact on the state's
185 ability to meet the health care cost growth benchmarks established by
186 the commission in accordance with subsection (e) of this section or on
187 the competitive market.

188 (2) The commission shall conduct a cost and market impact review
189 relating to such material change in operations or governance structure
190 that shall include, but need not be limited to, consideration of the
191 following: (A) Whether the health care provider or provider
192 organization has a dominant market share for the services it provides;
193 (B) whether the health care provider or provider organization charges
194 prices for services that are materially higher than the median prices
195 charged by other health care providers for the same services in the
196 same market; (C) the quality of services offered by the health care
197 provider or provider organization; (D) the availability and accessibility
198 of services similar to those provided or proposed to be provided in the
199 primary service areas; (E) the impact on competing options for the

200 delivery of health care services in the primary service area; (F) the role
201 of the health care provider or provider organization in serving at-risk
202 and underserved populations, including those receiving state medical
203 assistance; and (G) any consumer concerns or complaints against the
204 health care provider or provider organization.

205 (3) After completing a cost and market impact review, the
206 commission shall issue a preliminary report. The health care provider
207 or provider organization that is the subject of the report may, not later
208 than thirty days after receiving such report, submit a written response
209 to the commission on the findings contained in the report. After
210 consideration of any response received from the health care provider
211 or provider organization, the commission shall issue a final report and
212 submit such report to the Attorney General for the Attorney General's
213 consideration.

214 (h) The Attorney General may review and analyze information
215 reported to the commission and may require that any health care
216 provider, health insurance carrier or provider organization submit
217 additional information or provide testimony under oath relating to
218 health care costs, factors that contribute to cost growth within the
219 state's health care system or the relationship between provider costs
220 and health insurance premium rates.

221 (i) The commission may assess health care providers and health
222 insurance carriers reasonable administrative fees to defray the costs of
223 implementing the provisions of this section.

224 (j) On or before January 1, 2017, and annually thereafter, the board
225 shall report, in accordance with section 11-4a of the general statutes, on
226 the commission's activities to the joint standing committee of the
227 General Assembly having cognizance of matters relating to public
228 health. The report shall include, but need not be limited to: (1)
229 Information on spending trends and underlying factors; (2)
230 recommendations for strategies to increase the efficiency of the health
231 care system; (3) recommendations to reduce provider price variation;
232 (4) information concerning cost, price, quality, utilization and market

233 power in the state's health care system; (5) cost growth trends for care
 234 provided within and outside of accountable care organizations and
 235 patient-centered medical homes; (6) cost growth trends by health care
 236 provider sector, including, but not limited to, hospitals, hospital
 237 systems, nonacute health care providers, pharmaceuticals, medical
 238 devices and durable medical equipment; (7) factors that contribute to
 239 cost growth within the state's health care system and to the
 240 relationship between health care provider costs and health insurance
 241 premium rates; (8) the proportion of health care expenditures
 242 reimbursed under fee-for-service and alternative payment
 243 methodologies; (9) the impact of health care payment and delivery
 244 reform efforts on health care costs including, but not limited to, the
 245 development of limited and tiered networks, increased price
 246 transparency, increased utilization of electronic medical records and
 247 other health technology; (10) trends in utilization of unnecessary or
 248 duplicative services, with particular emphasis on imaging and other
 249 high-cost services; (11) the prevalence and trends in adoption of
 250 alternative payment methodologies and impact of alternative payment
 251 methodologies on overall health care spending, health insurance
 252 premiums and health care provider rates; (12) the development and
 253 status of health care provider organizations in the state including, but
 254 not limited to, acquisitions, mergers, consolidations and any evidence
 255 of excess consolidation or anti-competitive behavior by provider
 256 organizations; and (13) the impact of health care payment and delivery
 257 reform on the quality of health care services delivered in the state.

258 (k) The board may adopt regulations, in accordance with chapter 54
 259 of the general statutes, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2015	New section

Statement of Legislative Commissioners:

In section 1(c)(1), "are a consumer of health care services" was changed to "have demonstrated expertise in health care consumer advocacy" for internal consistency.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: See below

Municipal Impact: None

Explanation

The bill establishes a new Commission on Health Care Policy and Cost Containment and enumerates its various duties and responsibilities. The Commission is established as an independent commission, not subject to the control of any executive officer or agency. It is required to appoint an executive director, who is responsible for the administrative affairs and general management of the commission.

Based on the various requirements detailed in the bill, it is assumed that the Commission will require extensive administrative resources to accomplish its duties. The extent of these costs will depend upon the number of employees hired by the Commission as well as any potential contracts undertaken, which cannot be known in advance. For purposes of comparison, the Department of Public Health's Office of Health Care Access (OHCA) has some similar broad health oversight responsibilities. In FY 15 OHCA employed 19 full time employees and had Personal Services and Other Expenses costs totaling \$1.9 million. The new Commission would further incur related fringe benefit and indirect overhead costs. Based on the OHCA staffing levels and the current ratios for special fund state agencies, these related costs could total an additional \$1.4 million.

The bill does not specify whether the Commission is a General Fund agency, nor whether its employees would receive state benefits.

Therefore, it is unclear whether costs related to the Commission would be considered state costs.

The bill specifies that the Commission may access health care providers and health insurance carriers in order to defray the costs related to the Commission. The bill does not specify the details of this assessment.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 815*****AN ACT ESTABLISHING A COMMISSION ON HEALTH CARE POLICY, COST CONTAINMENT AND PRICE VARIATION.*****SUMMARY:**

This bill establishes a Commission on Health Care Policy and Cost Containment as an independent administrative commission. Among other things, it must:

1. establish annual statewide benchmarks for the growth of health care costs,
2. monitor and review the impact of health care marketplace changes,
3. review variations in health care providers' prices and insurance reimbursement rates,
4. monitor the financial conditions of acute care hospitals, and
5. annually report on its activities to the Public Health Committee, starting by January 1, 2017.

The bill also requires health care providers and provider organizations to notify the commission before making any material change to their operations or governance structure. (The bill does not define this term. Presumably, it includes at least mergers, consolidations, and hospital conversions.) The commission must conduct a cost and market impact review of the proposed change and submit it to the attorney general.

The bill establishes a 14-member board of directors to govern the commission and requires it to appoint an executive director to

supervise the commission's general operations and administrative affairs. The executive director does not need approval from any executive agency to appoint employees and may establish personnel policies and regulations for the commission's officers and staff.

The bill authorizes the commission to assess health care providers and insurance carriers a reasonable administrative fee to cover its costs. (The bill does not specify the assessment's frequency or how it will be calculated.)

The bill authorizes the board to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2015

COMMISSION'S BOARD OF DIRECTORS

Membership

The board consists of ex-officio, non-voting members and appointed members. The ex-officio, non-voting members are the public health (DPH), social services, and insurance commissioners and health care advocate, or their designees. Appointed members are listed in Table 1 below.

<i>Appointing Authority</i>	<i>Number of Members</i>	<i>Qualification</i>	<i>Initial Appointment Term</i>
Senate president pro tempore	1	demonstrated expertise in health care delivery or management at a senior level	five years and until a successor's appointment
House speaker	1	demonstrated expertise in health care consumer advocacy	three years and until a successor's appointment
Senate majority leader	1	expertise in behavioral health and its reimbursement systems	five years and until a successor's appointment
House majority leader	1	expertise as an institutional purchaser of health insurance or health care services	bill does not specify
Senate minority	1	demonstrated	three years and until

leader		expertise in the development and utilization of innovative medical technologies and treatments for patient care	a successor's appointment
House minority leader	1	demonstrated expertise in health plan administration and finance, including payment methodologies	five years and until a successor's appointment
Public Health Committee Senate chairperson	1	expertise in representing the healthcare workforce as a labor organization leader	three years and until a successor's appointment
Public Health Committee House chairperson	1	primary care physician	three years and until a successor's appointment
Public Health Committee Senate ranking member	1	expertise as a health insurance purchaser representing business management or health benefits administration	three years and until a successor's appointment
Public Health Committee House ranking member	1	health economist	three years and until a successor's appointment

The bill does not specify when appointing authorities must make their initial appointments. Board members are eligible for reappointment under the same conditions as for initial appointments. Subsequent appointments are for three-year terms. Appointing authorities must fill any vacancies for the expiration of an outgoing member's term in the same manner as initial appointments.

Members are not paid but are reimbursed for actual expenses incurred in serving on the board.

Operations

Under the bill, the board must annually select a chairperson and

vice-chairperson from among its members. The board must meet (1) at least quarterly, (2) upon the request of any two members, and (3) at least annually with people and groups affected by its policies and procedures.

A majority of the board members constitutes a quorum, and a majority vote of a quorum is required for any official action. The chairperson must decide a tie vote. The bill requires the board to adopt its own rules for conducting meetings.

COMMISSION DUTIES AND RESPONSIBILITIES

Under the bill, the commission must:

1. set the state's health care cost growth goals;
2. enhance the transparency of provider organizations (e.g., physician organizations, provider networks, or independent practice associations);
3. monitor the development of accountable care organizations (ACOs) and medical homes;
4. monitor the adoption of alternative payment methodologies;
5. foster innovative health care delivery and payment models that lower health care cost growth and improve patient care quality;
6. monitor and review the impact of health care marketplace changes;
7. protect patient access to necessary health care services;
8. hold public hearings at least annually to examine health care provider, provider organization, and health insurance carrier costs, prices, and cost trends, focusing on contributing factors of the state's health care cost growth;
9. establish annual health care cost growth benchmarks for the average growth in total health care spending and publish them

- on the commission's website;
10. establish procedures to help health care providers that exceed these benchmarks to improve efficiency and reduce cost growth, including implementing performance improvement plans;
 11. provide written notice to providers who exceed the health care cost growth benchmarks and help them implement performance improvement plans;
 12. develop and administer a required registration program for providers and provider organizations that prohibits those who do not register from negotiating contracts with health insurance carriers or third-party administrators;
 13. require registered provider organizations to report data the commission deems necessary to better protect the public's interest in monitoring the organizations' financial condition, organizational structure, business practices, and market share;
 14. review and comment on all capital expenditure projects that require a certificate of need from DPH's Office of Health Care Access;
 15. ensure uniform reporting of health care revenue, charges, costs, prices, service utilization, and other data the commission requires to analyze changes in (a) health insurance premium levels, plan benefits, and cost-sharing; (b) measures of health insurance plan cost and utilization; and (c) payment methods; and
 16. enter into contracts or take other necessary action to carry out its duties.

Reviewing Price and Insurance Reimbursement Rate Variations

The bill requires the commission to review variation in health care providers' prices and insurance reimbursement rates. It must review the information by payer and provider type and:

1. identify factors contributing to price and reimbursement and variation;
2. assess the impact of the variation on health care costs, insurance premiums, safety net providers, and access to care; and
3. recommend policy changes to reduce provider price variations that are unrelated to actual cost or quality differences or unnecessarily contribute to health care cost inflation.

Monitoring Financial Conditions of Acute Care Hospitals

The bill requires the commission to collect and analyze any necessary data to monitor the financial conditions of acute care hospitals, including:

1. gross and net patient service revenues;
2. revenue sources;
3. trends in the availability and utilization of hospital, nursing home, and outpatient clinic services;
4. salary and benefit information, including total payroll as a percentage of operating expenses; and
5. other relevant measures of health care facilities' financial health or distress.

REVIEWING MATERIAL CHANGES TO THE HEALTH CARE PROVIDER MARKET

Notice Requirement

The bill requires health care providers and provider organizations to notify the commission in writing before making any material change in their operations or governance structure. (The bill does not define this term. Certain transactions already require a certificate of need or notification to the attorney general (AG). Nonprofit hospital conversions require approval from DPH and the AG.) They must also,

upon request, submit information the commission deems necessary to determine whether the proposed change will significantly impact the (1) state's ability to meet its health care cost growth benchmarks or (2) competitive market.

Cost and Market Impact Review

The bill requires the commission to conduct a cost and market impact review (CMIR) of the proposed material change that considers:

1. whether the provider or provider organization (a) has a dominant market share for the services it provides and (b) charges prices materially higher than the median prices charged by other providers for the same services in the same market;
2. the quality of services the provider or provider organization offers and the availability and accessibility of similar services in their primary service areas;
3. the impact on competing options for health care service delivery in their primary service areas;
4. the provider's or provider organization's role in serving at-risk and underserved populations, including Medicaid recipients; and
5. any consumer concerns or complaints against the provider or provider organization.

After completing the CMIR, the commission must issue a preliminary report and allow its subject (i.e., the health care provider or provider organization) to respond in writing within 30 days after receiving it. After considering any response it receives, the commission must issue its final report and submit it to the attorney general.

The AG may review and analyze information reported to the commission and require any health care provider, health insurance carrier, or provider organization to submit additional information or provide testimony under oath on (1) health care costs, (2) contributing

factors to health care system cost growth, or (3) the relationship between provider costs and insurance premium rates.

REPORTING REQUIREMENTS

Commission's Annual Report

By January 1, 2017, the board must begin annually reporting on the commission's activities to the Public Health Committee. The report must include:

1. information on spending trends and underlying factors;
2. recommendations for strategies to increase the health care system's efficiency;
3. recommendations to reduce provider price variation;
4. information on cost, price, quality, utilization, and market power in Connecticut's health care system;
5. cost growth trends for care provided within and outside of ACOs and patient-centered medical homes;
6. cost growth trends by health care provider sector, including hospitals, hospital systems, non-acute health care providers, pharmaceuticals, medical devices, and durable medical equipment;
7. contributing factors to the state's health care system cost growth and the relationship between provider costs and insurance premium rates;
8. the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methods;
9. the impact of health care payment and delivery reform efforts on health care costs, including the development of limited and tiered provider networks, increased price transparency, increased use of electronic medical records, and other health

technology;

10. trends in utilization of unnecessary or duplicative services, particularly imaging and other high-cost services;
11. the prevalence and trends in adopting alternative payment methods and their impact on overall health care spending, insurance premiums, and provider rates;
12. the development and status of health care provider organizations in Connecticut, including acquisitions, mergers, consolidations, and any evidence of excess consolidation or anti-competitive behavior by provider organizations; and
13. the impact of health care payment and delivery reform on the quality of services delivered in Connecticut.

State Agencies and Health Care Providers

The bill authorizes the commission's board to request from a (1) state office, department, board, or other agency or (2) health care provider, health insurance carrier, or provider organization any reports, information, or assistance that may be necessary or appropriate for the commission to fulfill its duties and responsibilities.

The board must consult with the insurance and DPH commissioners and the Connecticut Insurance Exchange to (1) avoid duplicative reporting requirements and (2) consolidate and simplify them as appropriate.

COMMITTEE ACTION

Public Health Committee

Joint Favorable

Yea 20 Nay 5 (03/30/2015)