Legislative Fiscal Bureau

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MO# passage as amended

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 11 NO 4 ABS

February 10, 1998

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Senate Substitute Amendment 1 to Senate Bill 315: Office of Health Care Information -- Collection of Health Care Data

Senate Substitute Amendment 1 to 315 would make numerous changes relating to the authority of the Department of Health and Family Services (DHFS) to collect and disseminate health care information. In addition, the substitute amendment would modify the composition and responsibilities of the Board on Health Care Information and the Interagency Coordinating Council.

Senate Bill 315 was developed by the Legislative Special Committee on Health Care Information. The bill was introduced by the Joint Legislative Council and referred to the Senate Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs on October 8, 1997.

On January 15, 1998, The Senate Committee adopted Senate Substitute Amendment 1 to SB 315 (SSA 1 to SB 315) and Senate Amendments 1 (as modified by SA 1), 2 and 3 to SSA 1 to SB 315. The Committee recommended passage of the bill as amended by a vote of 5 to 0.

CURRENT LAW

Office of Health Care Information. The DHFS Office of Health Care Information (OHCI) is required to collect, analyze and disseminate information about hospital services utilization, charges, revenues, expenditures, mortality and morbidity rates, health care coverage and uncompensated health care services. In addition to data on hospitals, OHCI collects information on selected hospital-based outpatient surgery and ambulatory surgery centers and other health

care providers. OHCI and the Board on Health Care Information, an advisory board attached to DHFS, are funded from assessments made on hospitals' respective gross private-pay patient revenues during each hospital's most recently concluded fiscal year. OHCI may also assess ambulatory surgery centers. In addition, OHCI must require user fees for providing data compilation or special reports.

Since April 1, 1992, OHCI has had the authority to collect, analyze and disseminate health care information from health care providers other than hospitals and ambulatory surgery centers, including physicians. However, without the authority to assess providers, other than hospitals and ambulatory surgery centers, OHCI has not had sufficient funding to collect health care information from providers other than hospitals and ambulatory surgery centers.

Board on Health Care Information. The Board is created under the direction and supervision of the DHFS Secretary. The Board consists of nine members, a majority of whom may neither be nor represent health care providers. The Board is responsible for the following: (a) advising the Department on the collection, analysis and dissemination of health care information; (b) approving contracts services related to the collection, analysis and dissemination of health care information; and (c) approving all rules proposed by DHFS relating to OHCI.

Interagency Coordinating Council. The Interagency Coordinating Council advises and assists state agencies in the coordination of health care data collection programs and the exchange of information related to health care data collection and dissemination, including the following: (a) agency budgets for health care data collection programs; (b) health care data monitoring and management; (c) public information and education; (d) health care data analysis and facilities; (e) research activities; and (f) the appropriation and allocation of state funds for health care data collection.

The Council is comprised of members representing various agencies, including: (a) the Secretary of Employee Trust Funds, or his or her designee; (b) a representative of the unit in DHFS that collects health statistics; (c) a representative in the unit of DHFS that administers the medical assistance program; (d) a representative in the unit of DHFS that collects health care information; (e) a representative in the unit in the University of Wisconsin System that conducts health statistics research analysis; and (f) a representative in the unit in the Department of Administration that is responsible for information technology.

1997 Wisconsin Act 27 transferred the OHCI and the Board on Health Care Information from the Office of Commissioner of Insurance to DHFS.

SUMMARY OF BILL

SSA 1 to SB 315 would make numerous modifications to the Department's authority and responsibility to collect and disseminate health care information. In addition, a number of revisions would be made to the Board on Health Care Information (Board) and the Interagency

Coordinating Council (Council). Unless otherwise noted, these modifications would first be effective on the day after publication of the bill.

Health Care Data Reports. SSA 1 to SB 315 would authorize DHFS to require health care providers to submit to the Department information that it deems necessary for the preparation of reports, plans and recommendations in a form specified by the Department by rule. If DHFS collects health care provider-specific data from health care plans, DHFS would be required to attempt to avoid collecting the same data from health care providers.

In addition, DHFS would be authorized to collect annual assessments from all health care providers who are in a class of health care providers from whom the Department collects data. These assessments could be used to support: (a) data collection; (b) data base development and maintenance; (c) generation of data files and standard reports; (d) orientation and training for providers; and (e) the Board's costs. The classes of health providers from whom DHFS would collect data and the methods and criteria for assessing those providers would be specified by DHFS by rule. This provision would replace the current provisions relating to the Department's authority to assess hospitals and ambulatory surgery centers for its health care data collection activities and operation of the Board.

DHFS would also be required to provide orientation and training to health care providers that submit data to OHCI. This training would explain the process of data collection and analysis and the procedures for data verification, interpretation and release.

SSA 1 to SB 315 would also delete current provisions relating to the following: (a) specific sources of health care information collected by OHCI, including statutory definitions of "charge elements" and "uniform patient billing forms;" (b) specific reports OHCI is required to prepare, except that the annual report prepared by DHFS and the annual plan submitted by hospitals related to uncompensated health care services would not be eliminated; and (c) specific procedures related to data verification and review, including the requirement that OHCI hold public hearings to elicit public comments on OHCI reports.

Instead, DHFS would be required to promulgate rules to specify the following: (a) the uniform data set of health care information to be collected by the Department; (b) the methods by which information would be collected, including procedures for submission of data by electronic means; (c) procedures for data verification and review; (d) the standard reports that would be issued by the Department; and (e) methods for using and disseminating health care data in order for health care providers to provide health care that is effective and economically efficient and for consumer and purchasers to make informed decisions in selecting health care plans and health care providers.

Voluntary Health Care Plan Reporting. SSA 1 to SB 315 would direct DHFS to study and, based on the results of the study, develop and implement a voluntary system of health care plan reporting that enables purchasers and consumers to assess the performance of health care plans and the health care providers that are employed or reimbursed by the health care plans.

DHFS would be required to undertake the study, develop and implement the system in cooperation with the Board, the Council, private health care purchasers, the Department of Employe Trust Funds, the Office of the Commissioner of Insurance, major associations of health care providers, health care plans and consumers.

If DHFS implemented such a system of voluntary reporting, it would be required to operate it so that purchasers, consumer, the public, the Governor and legislators could assess the performance of health care plans and health care providers. DHFS would be required to specify by rule the information that would be collected under this system. However, if DHFS collects health care provider-specific information from health care plans, it would be required to attempt to avoid collecting the same data from those health care providers.

DHFS would also be required to estimate the total cost of the collection, database development and maintenance and generation of public data files and standard reports for health care providers that voluntary agree to supply health care data under this system. DHFS would assess the estimated total cost to health care providers in a manner specified by rule. The methods and criteria for assessing these providers would be specified by DHFS by rule.

Consumer Guide. SSA 1 to SB 315 would require DHFS to prepare and submit to the Governor and the Legislature an annual guide to assist consumers in selecting health care providers and health care plans. DHFS would specify by rule the information to be provided in the consumer guide. The consumer guide would be written in a language that is understandable to lay persons. DHFS would be required to widely publicize and distribute the guide to consumers.

Confidentiality Provisions. SSA 1 to SB 315 would require DHFS to prohibit purchasers of data from rereleasing "individual data elements" of health care data files. DHFS would define individual data elements by rule. Any person who violates this provision would be required to forfeit not more than $100 for each violation.

In addition, DHFS would be prohibited from releasing any health care information until all required verification and review procedures have been complied with, except that health care provider-specific information could be released to the provider to whom the information relates. An individual who violates this provision could be fined no more than $10,000 or imprisoned for not more than nine months or both.

SSA 1 to SB 315 would also make the malicious use, or threat to use, the patient health care records of another person, with intent to extort money or any pecuniary advantage, or with intent to compel the person threatened to do any act against the person's will or omit to do any lawful act a Class D felony.

Hospital Rates. SSA 1 to SB 315 would modify current law provisions relating to notification of hospital rate increases. Under current law, before a hospital can increase its rates by more than the increase in the consumer price index, it must publish a notice and hold a public

hearing. The notice must be published in the area where the hospital is located or in an official state newspaper. The substitute amendment would eliminate the public hearing requirement and the option to publish the notice in an official state newspaper.

Charity Care and Bad Debt Report. The substitute amendment contains non-statutory provisions that would require DHFS to prepare a report on the feasibility of requiring major health care providers, other than hospitals, to report annually on services provided as either charity care or bad debt services and to prepare an annual plan on projected services that would be provided as charity care or bad debt services, in the same manner as the annual report and plan required for hospitals. DHFS would be required to submit this report to the Legislature, the Board and the Governor an the first day of the 7th month after publication of the bill.

Treatment of Contract Fees. SSA 1 would specify that all contract fees DHFS collects from the Group Insurance Board for the provision of data collection and analysis services related to HMOs and insurance companies that provide health insurance for state employes be credited to the DHFS program revenue appropriation used to support DHFS general program operations for its health care information activities. Currently, this revenue is credited to the Department's interagency and intra-agency programs appropriation for the Division of Health.

Board on Health Care Information. SSA 1 to SB 315 would require the Governor to nominate and the Senate to approve the appointment of individuals to the Board. These provisions would apply to persons appointed to the Board on the effective date of the bill. In addition, SSA 1 to SB 315 would require the Board and DHFS to jointly do the following: (a) develop all required and authorized OHCI rules; (b) provide oversight on OHCI standard reports; (c) develop the overall strategy and direction for OHCI; and (d) provide information on their activities to the Interagency Coordination Council. Finally, SSA 1 to 315 would eliminate provisions that require the Board to approve OHCI contracts.

Interagency Coordinating Council. SSA 1 to SB 315 would add a representative of the of the Office of the Commissioner of Insurance to the Council. This individual would serve for an initial term that expires on July 1, 2003. In addition, the substitute amendment would require the Council to establish methods and criteria for analyzing and comparing complaints filed against health care plans and grievances filed with health maintenance organizations (HMOs). However, these methods could not require the collection of information in addition to information already collected by state agencies.

Bureau of Health Care Information. SSA 1 to SB 315 would create a Bureau of Health Care Information (Bureau) within DHFS to administer the collection, analysis and dissemination of health care information. The substitute amendment would require the Bureau to coordinate its activities with persons responsible for administration of the medical assistance program and persons responsible for the collection and analysis of health statistics.

SUMMARY OF AMENDMENTS

Senate Amendment 1

Senate Amendment 1 to SSA 1 would increase membership on the Board from nine to ten members and require that five members be or represent health care providers. At least one, but not more than two members would be physicians. The 10th member would be appointed for an initial term expiring on May 1, 2002. Senate Amendment 1 to SA 1 would permit the State Medical Society to recommend Board membership for up to five physicians, one of whom the Governor would appoint to the Board.

Senate Amendment 2

This amendment creates the following provisions relating to the disclosure of personal medical information. These provision would be effective on the first day of the 13th month beginning after publication of the bill.

Definitions. SA 2 to SSA 1 to SB 315 defines the following terms:

"Health care provider" is defined as any person licensed, registered or permitted or certified by DHFS or the Department of Regulation and Licensing to provide health care services, items or supplies in this state.

"Individual" is defined as a natural person who is a resident of this state. For these purposes, a person is a state resident if his or her last-known mailing address, according to the records of an insurer or insurance support organization, was in the state.

"Insurance support organization" is defined as any person that regularly engages in assembling or collecting personal medical information about natural persons for the primary purpose of providing the personal medical information to insurers for insurance transactions, including the collection of personal medical information from insurers and other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentations or material nondisclosure in connection with insurance underwriting or insurance claim activity. Insurance support organization does not include insurance agents, government institutions, insurers or health care providers.

"Insurance transaction" is defined as any of the following involving insurance that is primarily for personal, family or household needs: (a) the determination of an individual's eligibility for an insurance coverage, benefit or payment; and (b) the servicing of an insurance application, policy, contract or certificate.

"Medical care institution" is defined as a continuing care facility as currently defined in statute, hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanitorium, adult family

home, assisted living facility, rural medical center, hospice or other place licensed, certified or approved by DHFS or certified by a county.

"Personal medical information" is defined as information concerning an individual that satisfies all of the following: (a) relates to the individual's physical or mental health, medical history or medical treatment; and (b) is obtained from a health care provider, a medical care institution, the individual or the individual's spouse, parent or legal guardian. Personal medical information does not include information that is obtained from the public records of a governmental authority and that is maintained by an insurer or its representative for the purpose of insuring title to repeal property located in this state.

Disclosure Authorization. Senate Amendment 2 would require that any form used in connection with an insurance transaction that authorizes the disclosure of personal medical information about an individual to an insurer would comply with all of the following: (a) all instructions and other information contained in the form is presented in plain language; (b) the form is dated; (c) the form specifies the types of persons that are authorized to disclose information about the individual; (d) the form specifies the nature of the information that is authorized to be disclosed; (e) the form names the insurer and identifies by generic reference representatives of the insurer, to whom the information is authorized to be disclosed; (f) the form specifies the purpose for which the information is being obtained; and (g) the form advises the individual, or an authorized representative of the individual, that the individual is entitled to receive a copy of the completed authorization form.

Authorization forms used for the purpose of obtaining information in connection with an insurance policy application, an insurance policy reinstatement or a request for a change in policy benefits may not exceed 30 months from the date on which the authorization is signed. Authorization forms that will be used for the purpose of obtaining information in connection with a claim for benefits under an insurance policy may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer.

Access to Recorded Personal Medical Information. Senate Amendment 2 specifies that if, after proper identification, an individual or an authorized representative of an individual submits a written request to an insurer for access to recorded personal medical information that concerns the individual and is in the insurer's possession, within 30 business days after receiving the request the insurer would be required to do all of the following:

1. Inform the individual or authorized representative in writing, by telephone or by any other means of communication at the discretion of the insurer of the nature and substance of the recorded personal medical information.

2. At the option of the individual or authorized representative, allow the individual or representative to inspect and copy the recorded personal medical information. This could be accomplished in person during the insurer's normal business hours or the insurer could provide

a copy by mail. If the information is in coded form, the insurer would be required to provide an accurate written translation in plain language.

3. Disclose to the individual or authorized representative the identities, if the insurer has kept a record, of any person to whom the insurer has disclosed the recorded personal information within the two years prior to the request. If the insurer did not record the identities, the insurer would be required to disclose the names of any insurance agents, insurance support organizations or other entities to whom this information is normally disclosed.

4. Provide to the individual or authorized representative a summary of the procedure by which a correction, amendment or deletion of any recorded personal medical information could be requested.

In addition, an insurer could, at the insurer's discretion, provide a copy of any recorded personal medical information requested by an individual or authorized representative to a health care provider who is designated by the individual or authorized representative. The health care provider must be licensed, registered, permitted or certified to provide health care services with respect to the condition to which the information relates. If the insurer does provide this information to a designated health care provider, the insurer would be required to notify the individual or authorized representative, at the time of the disclosure, that the information was provided to the health care provider.

An insurer would only be required to disclose this information to an individual, authorized representative or designated health care provider under the following conditions: (a) the request includes a reasonable description of the information that is being requested; (b) the information is reasonably easy to locate and retrieve by the insurer; (c) the information was not collected in connection with or in anticipation of a claim or civil or criminal proceeding involving the individual; and (d) the insurer has not received this information from a health care provider or medical institution with instructions restricting the disclosure of the information to the individual. If the insurer has received such instructions, the insurer would be required to disclose the identity of the health care provider or medical care institution that provided the information to the individual.

Any copy of recorded personal medical information provided to an individual or authorized representative must include the identity of the source of the information, if the source is a health care provider or medical care institution. Insurers would also be authorized to charge an individual a reasonable fee to cover the costs of providing this information. The amendment further specifies that the requirements applying to an insurer could be satisfied by another insurer, an insurance agent, an insurance support organization or any other entity authorized by the insurer to act on its behalf.

Correction, Amendment or Deletion of Recorded Personal Information. The amendment specifies that within 30 days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer's

possession, an insurer would be required to either comply with the request or notify the individual of its refusal to comply.

If the insurer complied with the request, it would be required to notify the individual of that compliance in writing and provide the correction, amendment or fact of deletion to all of the following: (a) any person who may have received, within the preceding two years, the recorded personal medical information concerning the individual and who is specifically designated by the individual; (b) any insurance support organization for which insurers are the primary source of personal medical information, if the insurer has systematically provided recorded personal medical information to the organization in the last seven years. This provision would not apply to an insurance support organization that does not maintain recorded personal medical information concerning the individual; and (c) any insurance support organization that has provided to the insurer the personal medical information that has been corrected, amended or deleted.

If the insurer refuses to comply with the request, it would be required to notify the individual of the following: (a) the reasons for the refusal; and (b) the individuals right to file a concise statement with the insurer, an insurance agent or an insurance support organization. This statement may include the following: (a) information the individual believes to be correct, relevant or fair; and/or (b) the reasons why the individual disagrees with the insurer's refusal to correct, amend or delete the recorded personal medical information.

If the individual files a statement, the insurer must do the following:

1. File the statement with the recorded personal medical information that is the subject of the request in such a way that any person reviewing the recorded personal medical information would be aware of and have access to the statement.

2. In any subsequent disclosure of the recorded personal medical information relating to the statement filed by the individual, clearly identify any matter in dispute and provide the statement along with the information.

3. Provide a copy of the statement to any person to whom the insurer would have been required to furnish a correction, amendment or fact deletion.

The provisions relating to the correction, amendment or deletion of recorded personal medical information would not apply to information concerning an individual that relates to and is collected in connection with or anticipation of a claim or civil or criminal proceeding involving the individual.

Disclosure of Personal Medical Information by Insurers. Under Senate Amendment 2, any disclosure of an individual's personal medical information by an insurer would be required to be consistent with the individual's signed disclosure authorization form, unless the disclosure meets any of the following criteria:

1. The disclosure is otherwise authorized by the individual, or by a person authorized to consent on behalf of an individual who lacks the capacity to consent.

2. The disclosure reasonably relates to the protection of an insurer's interests in the assessment of causation, fault or liability or in the detection or prevention of criminal activity, fraud, material misrepresentation or material nondisclosure.

3. The disclosure is made to an insurance regulatory authority or in response to an administrative or judicial order, including a search warrant or subpoena, that is valid on its face.

4. The disclosure is otherwise permitted by law.

5. The disclosure is made for the purposes of pursing a contribution to a subrogation claim.

6. The disclosure is made to a professional peer review organization, bill review organization, health care provider or medical consultant or reviewer for the purpose of reviewing the services, fees, treatment or conduct of a medical care institution or health care provider.

7. The disclosure is made to a medical care institution or health care provider for verifying insurance coverage or benefits or for conducting an audit to verify the individuals treated by the health care provider or at the medical care institution.

8. The disclosure is made to a network plan that is offered by an insurer in order to make arrangements for coordinated health care in which personal medical information concerning an individual is available for providing treatment, making a payment for health care under the plan and undertaking plan operations that are necessary to fulfill the contract for provision of coordinated health care.

9. The disclosure is made to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurer's operations or services and the disclosure is reasonably necessary for the group policyholder to conduct the review or audit.

10. The disclosure is made in order to enable business decisions relating to the purchase, transfer, merger, reinsurance or sale of all or part of an insurance business.

11. The disclosure is made for the purposes of actuarial or research studies or for accreditation or auditing. If information is disclosed for these purposes, any materials that allow for the identification of an individual must be returned to the insurer or destroyed as soon as reasonably practicable. No actuarial, research, accreditation or auditing report that includes this information may identify an individual.

12. The disclosure is made to the insurer's legal representative for the purposes of claims review or legal advice or defense.

Immunity. A person would not be liable to any person for any of the following: (a) disclosing personal medical information in accordance with the provisions included in the amendment; and (b) providing personal medical information to an insurer or insurance support organization in accordance with the provisions included in the amendment. However, a person that discloses or provides false information with malice or intent to injure any person would be liable.

Obtaining Information Under False Pretenses. The amendment specifies that any individual who knowingly or willfully obtains information about an individual from an insurer or insurance support organization under false pretenses may be fined not more than $10,000 or imprisoned for not more than one year in county jail, or both.

Disclosure by Insurers of Personal Medical Information. Under these provisions, if a contract containing terms or provisions that were inconsistent with these new provisions relating to disclosure of personal medical information was in effect on the first day of the 13th month beginning after publication and it had not been issued or renewed after the effective date of the bill, these provisions would first apply to that contract upon its renewal.

Senate Amendment 3

Under SSA 1 to SB 315, health care providers could be required to submit information to DHFS that it deems necessary for the preparation of reports, plans and recommendations. Senate Amendment 3 would authorize DHFS to waive these health care data submission requirements for physicians. DHFS could waive these requirements if a physician requested a waiver and presented evidence to the Department that the data submission requirements were burdensome. A burdensome standard would be developed by DHFS by rule. The Department would also be required to develop a form that physicians would use in order to request a waiver. It should be noted that these waiver provisions would only apply to physicians and not to any other non-institutional providers, such as dentists or chiropractors.

Senate Amendment 4

Senate Amendment 4 was introduced on January 21, 1998. The amendment specifies that all contract fees DHFS collects from the Group Insurance Board for the provision of data collection and analysis services related to HMOs and insurance companies that provide health insurance for state employes be credited to the DHFS program revenue appropriation for money's received from other state agencies. Funds deposited in this appropriation are to be used to support the administration of programs for which the money was received. Under SSA 1 to SB 315, these contract fees would be deposited in the DHFS appropriation for general program operations for its health care information activities.

The amendment would require the Board to approve the amounts of assessments for health care providers, other than hospitals and ambulatory surgery centers. In addition, SA 4 would require DHFS and the Department of Regulation and Licensing to work together to develop a

MO# SA 1 to SA 1 to SSA 1

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 14 NO 1 ABS 1

MO# SA 1 (as amended) to SSA 1 (LRB 1341/4)

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 14 NO 1 ABS 1

UC to table

MO# SA 3 to SSA 1

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE ____ NO ____ ABS ____

DHFS staff indicate that if SSA 1 to SB 315, as amended, were enacted, the Department would utilize its new authority to collect data from providers other than hospitals to collect physician encounter data. DHFS would undertake the collection of physician encounter data as a project. The Department's estimated cost of implementing a two-year

UC to table

MO# SA 4 to SSA 1

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE ____ NO ____ ABS ____

UC to table

MO# SA 2 to SSA 1

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE ____ NO ____ ABS ____

MO# SSA 1 as amended

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 15 NO 0 ABS 1

Prepared by: Amie T. Goldman

MO# UC to roll all amendments into Sub

BURKE	Y	N	A
DECKER	Y	N	A
JAUCH	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
SCHULTZ	Y	N	A
ROSENZWEIG	Y	N	A
GARD	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
PORTER	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE ____ NO ____ ABS ____