



Senate

General Assembly

File No. 571

January Session, 2011

Substitute Senate Bill No. 1154

Senate, April 18, 2011

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 CONCERNING THE REPORTING OF CLAIMS INFORMATION TO THE COMPTROLLER AND ADDITIONAL DUTIES OF THE COMPTROLLER.

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

1 Section 1. (NEW) (*Effective July 1, 2011*) (a) Not later than October
2 first, annually, each municipality that sponsors a fully-insured group
3 health insurance policy or plan for its active employees, early retirees
4 and retirees that provides coverage of the type specified in
5 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
6 general statutes shall submit electronically to the Comptroller, in a
7 form prescribed by the Comptroller, the following information for the
8 policy or plan year immediately preceding:

9 (1) A list of each type of health insurance policy or plan offered to a
10 municipality's employees, early retirees and retirees and specific
11 details for each such policy or plan, including, but not limited to:

12 (A) Covered benefits and any limits on such benefits;

13 (B) (i) The total premium costs for each policy or plan, organized by
14 coverage tier, including, but not limited to, single, two-person and
15 family including dependents for (I) active employees, (II) early retirees,
16 and (III) retirees, and (ii) the employee share, the early retiree share
17 and the retiree share of each such total premium cost;

18 (C) Employee, early retiree and retiree cost-sharing requirements
19 such as coinsurance, copayments, deductibles or other out-of-pocket
20 expenses associated with in-network and out-of-network providers;
21 and

22 (D) If a municipality sponsors a prescription drug plan, the value of
23 any rebates or cost reductions provided to such municipality for such
24 plan;

25 (2) A list of the total number of employees, early retirees and
26 retirees in each policy or plan, organized by (A) municipal department,
27 (B) collective bargaining unit, if applicable, (C) coverage tier,
28 including, but not limited to, single, two-person and family including
29 dependents, and (D) active employee, early retiree or retiree status;
30 and

31 (3) For the two policy or plan years immediately preceding, the
32 percentage increase or decrease in the policy or plan costs, calculated
33 as the total premium costs, inclusive of any premiums or contributions
34 paid by active employees, early retirees and retirees, divided by the
35 total number of active employees, early retirees and retirees covered
36 by such policy or plan.

37 (b) No municipality submitting information pursuant to
38 subsection (a) of this section shall include health information in such
39 information.

40 Sec. 2. Section 38a-513f of the general statutes is repealed and the
41 following is substituted in lieu thereof (*Effective July 1, 2011*):

42 (a) As used in this section:

43 (1) "Claims paid" means the amounts paid for the covered
44 employees of an employer by an insurer, health care center, hospital
45 service corporation, medical service corporation or other entity as
46 specified in subsection (b) of this section for medical services and
47 supplies and for prescriptions filled, but does not include expenses for
48 stop-loss coverage, reinsurance, enrollee educational programs or
49 other cost containment programs or features, administrative costs or
50 profit.

51 (2) "Employer" means any town, city, borough, school district,
52 taxing district or fire district employing more than fifty employees.

53 (3) "Utilization data" means (A) the aggregate number of procedures
54 or services performed for the covered employees of the employer, by
55 practice type and by service category, or (B) the aggregate number of
56 prescriptions filled for the covered employees of the employer, by
57 prescription drug name.

58 (b) (1) Each insurer, health care center, hospital service corporation,
59 medical service corporation or other entity delivering, issuing for
60 delivery, renewing, amending or continuing in this state any group
61 health insurance policy providing coverage of the type specified in
62 subdivisions (1), (2), (4), (11), ~~[and] (12)~~ and (16) of section 38a-469
63 shall:

64 [(1)] (A) Disclose to an employer sponsoring such policy, upon
65 request by such employer, the following information for the most
66 recent thirty-six-month period or for the entire period of coverage,
67 whichever is shorter, ending not more than sixty days prior to the date
68 of the request, in a format as set forth in [subdivision (3)]
69 subparagraph (C) of this [subsection] subdivision:

70 [(A)] (i) Complete and accurate medical, dental and pharmaceutical
71 utilization data, as applicable;

72 [(B)] (ii) Claims paid by year, aggregated by practice type and by
73 service category, each reported separately for in-network and out-of-

74 network providers, and the total number of claims paid;

75 [(C)] (iii) Premiums paid by such employer by month; and

76 [(D)] (iv) The number of insureds by coverage tier, including, but
77 not limited to, single, two-person and family including dependents, by
78 month;

79 [(2)] (B) Include in such requested information specified in
80 [subdivision (1)] subparagraph (A) of this [subsection] subdivision
81 only health information that has had identifiers removed, as set forth
82 in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR
83 160.103, and is permitted to be disclosed under the Health Insurance
84 Portability and Accountability Act of 1996, P.L. 104-191, as amended
85 from time to time, or regulations adopted thereunder; and

86 [(3)] (C) Disclose such requested information [(A)] (i) in a written
87 report, [(B)] (ii) through an electronic file transmitted by secure
88 electronic mail or a file transfer protocol site, or [(C)] (iii) through a
89 secure web site or web site portal that is accessible by such employer.

90 [(c)] (2) Such insurer, health care center, hospital service
91 corporation, medical service corporation or other entity shall not be
92 required to provide such information to the employer more than once
93 in any twelve-month period.

94 [(d)] (3) Information disclosed to an employer pursuant to this
95 [section] subsection shall be used by such employer only for the
96 purposes of obtaining competitive quotes for group health insurance
97 or to promote wellness initiatives for the employees of such employer.

98 [(e)] (4) Any information disclosed to an employer in accordance
99 with this [section] subsection shall not be subject to disclosure under
100 section 1-210. An employee organization, as defined in section 7-467,
101 that is the exclusive bargaining representative of the employees of such
102 employer shall be entitled to receive claim information from such
103 employer in order to fulfill its duties to bargain collectively pursuant
104 to section 7-469.

105 [(f)] (5) If a subpoena or other similar demand related to information
106 disclosed pursuant to this section is issued in connection with a
107 judicial proceeding to an employer that receives such information,
108 such employer shall immediately notify the insurer, health care center,
109 hospital service corporation, medical service corporation or other
110 entity that disclosed such information to such employer of such
111 subpoena or demand. Such insurer, health care center, hospital service
112 corporation, medical service corporation or other entity shall have
113 standing to file an application or motion with the court of competent
114 jurisdiction to quash or modify such subpoena. Upon the filing of such
115 application or motion by such insurer, health care center, hospital
116 service corporation, medical service corporation or other entity, the
117 subpoena or similar demand shall be stayed without penalty to the
118 parties, pending a hearing on such application or motion and until the
119 court enters an order sustaining, quashing or modifying such
120 subpoena or demand.

121 (c) (1) Not later than October first, annually, each insurer, health
122 care center, hospital service corporation, medical service corporation
123 or other entity delivering, issuing for delivery, renewing, amending or
124 continuing in this state any group health insurance policy sponsored
125 by an employer and providing coverage of the type specified in
126 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall
127 submit to the Comptroller the information set forth in subparagraph
128 (A)(i) and (A)(ii) of subdivision (1) of subsection (b) of this section for
129 the policy year immediately preceding for each such employer.

130 (2) Such information shall be submitted electronically to the
131 Comptroller, in a form prescribed by the Comptroller, regardless of
132 whether an employer requests such information pursuant to
133 subparagraph (A) of subdivision (1) of subsection (b) of this section.
134 Disclosure of any such information to the Comptroller pursuant to this
135 subsection shall be made in compliance with subparagraph (B) of
136 subdivision (1) of subsection (b) of this section.

137 (3) The Comptroller shall maintain any information disclosed in

138 accordance with this subsection as confidential and such information
139 shall not be subject to disclosure under section 1-210.

140 (d) Not later than January 1, 2012, and annually thereafter, the
141 Comptroller shall submit a report, in accordance with section 11-4a, to
142 the joint standing committees of the General Assembly having
143 cognizance of matters relating to appropriations, insurance, labor and
144 planning and development, that provides estimated costs or savings
145 for each employer for which information was submitted pursuant to
146 subsection (c) of this section and section 1 of this act if such employer
147 was to obtain health benefits coverage of the type specified in
148 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 from the
149 group hospitalization and medical and surgical insurance plans
150 established under subsection (a) of section 5-259.

151 Sec. 3. (*Effective July 1, 2011*) (a) With respect to the group
152 hospitalization and medical and surgical insurance plans established
153 under subsection (a) of section 5-259 of the general statutes, on and
154 after July 1, 2011, and until June 30, 2015:

155 (1) The office of the State Comptroller shall have the authority to
156 convene a group including, but not limited to, (A) to the extent
157 applicable, health insurance companies, health care centers, hospital
158 service corporations, medical service corporations or other entities
159 delivering, issuing for delivery, renewing, amending or continuing
160 such plans, (B) third-party administrators providing administrative
161 services only for such plans pursuant to subdivision (2) of subsection
162 (m) of section 5-259 of the general statutes, (C) health care providers,
163 (D) health care facilities, (E) the Office of Policy and Management, and
164 (F) state employees and retirees, to facilitate the development and
165 establishment of health care provider payment reforms for the group
166 hospitalization and medical and surgical insurance plans established
167 under subsection (a) of section 5-259 of the general statutes, including,
168 but not limited to, multipayer initiatives, patient-centered medical
169 homes, primary care case management, value-based purchasing and
170 bundled purchasing. Any participation by such entities and

171 individuals shall be on a voluntary basis.

172 (2) (A) The Comptroller, or the Comptroller's designee, may (i)
173 conduct a survey of the entities and individuals specified in
174 subparagraphs (A) to (D), inclusive, of subdivision (1) of this
175 subsection, concerning payment delivery reforms, and (ii) convene
176 meetings at a time and place that is convenient for such entities and
177 individuals.

178 (B) The Comptroller, or the Comptroller's designee, shall ensure that
179 no such survey or meeting participants shall solicit, share or discuss
180 pricing information.

181 (C) (i) Any survey conducted pursuant to subparagraph (A) of this
182 subdivision shall not be a violation of chapter 624 of the general
183 statutes or subject to disclosure under section 1-210 of the general
184 statutes.

185 (ii) Any meeting convened pursuant to subparagraph (B) of this
186 subdivision shall not be a violation of chapter 624 of the general
187 statutes or constitute a meeting for the purposes of chapter 14 of the
188 general statutes.

189 (3) (A) If the Comptroller determines that entering a cooperative
190 agreement with any of the entities or individuals specified in
191 subparagraphs (A) to (D), inclusive, of subdivision (1) of this
192 subsection will likely produce efficiencies and improvements in health
193 care outcomes, the Comptroller may enter into one or more such
194 agreements to (i) identify and reward high quality, low-cost health
195 care providers, (ii) create enrollee incentives to receive care from such
196 providers, and (iii) create enrollee incentives to promote personal
197 health behaviors that will prevent or effectively manage chronic
198 diseases, including, but not limited to, tobacco cessation, weight
199 control and physical activity.

200 (B) The Comptroller may establish guidelines for such cooperative
201 agreements. Any such agreement shall be consistent with federal

202 antitrust laws and regulations promulgated by the Federal Trade
203 Commission and chapter 624 of the general statutes.

204 (b) Not later than January 1, 2016, the Comptroller shall submit a
205 report, in accordance with section 11-4a of the general statutes, to the
206 joint standing committees of the General Assembly having cognizance
207 of matters relating to appropriations, labor and public health on the
208 effectiveness of the Comptroller's convenor authority set forth in
209 subsection (a) of this section. Such report shall include, but not be
210 limited to, (1) any cost containment measures implemented as a result
211 of the activities set forth in subsection (a) of this section, (2)
212 descriptions of any quality measurement or quality improvement
213 initiatives implemented as a result of the activities set forth in
214 subsection (a) of this section, and (3) any cost savings or health
215 outcome improvements associated with such measures or initiatives.

216 Sec. 4. Section 19a-654 of the general statutes is repealed and the
217 following is substituted in lieu thereof (*Effective July 1, 2011*):

218 (a) [The Office of Health Care Access division of the Department of
219 Public Health shall require] Each short-term acute care general or
220 children's [hospitals to] hospital and each licensed out-patient surgical
221 facility shall submit such data, including inpatient data, out-patient
222 data, if any, and discharge data [, as it deems] necessary to fulfill the
223 responsibilities of the [office] Office of Health Care Access division of
224 the Department of Public Health. Such data shall include data taken
225 from medical record abstracts and hospital bills. The timing and
226 format of such submission shall be specified by the office. The data
227 may be submitted through a contractual arrangement with an
228 intermediary. If the data is submitted through an intermediary, the
229 hospital shall ensure that such submission is timely and that the data is
230 accurate. The office may conduct an audit of the data submitted to
231 such intermediary in order to verify its accuracy. Individual patient
232 and physician data identified by proper name or personal
233 identification code submitted pursuant to this section shall be kept
234 confidential, but aggregate reports from which individual patient and

235 physician data cannot be identified shall be available to the public.

236 (b) Not later than October 1, 2011, the Office of Health Care Access
237 shall enter into a memorandum of understanding with the
238 Comptroller that shall permit the Comptroller to access the data set
239 forth in subsection (a) of this section, provided the Comptroller agrees,
240 in writing, to keep individual patient and physician data identified by
241 proper name or personal identification code and submitted pursuant
242 to this section confidential.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2011	New section
Sec. 2	July 1, 2011	38a-513f
Sec. 3	July 1, 2011	New section
Sec. 4	July 1, 2011	19a-654

INS *Joint Favorable C/R* PD

PD *Joint Favorable C/R* PH

PH *Joint Favorable Subst.*

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:

Agency Affected	Fund-Effect	FY 12 \$	FY 13 \$
Public Health, Dept.	GF - Cost	\$99,584	\$84,584
State Comptroller - Fringe Benefits ¹	GF - Cost	\$16,296	\$16,296

Note: GF=General Fund

Municipal Impact: None, See below for out years

Explanation

The bill results in a General Fund cost of \$115,880 in FY 12, and \$100,880 in FY 13, to expand data collection under the Office of Health Care Access (OHCA, a division of the Department of Public Health).

Currently, OCHA collects and processes data from acute care and children's hospitals. Patient records from outpatient surgical facilities are not collected and processed. An estimated 200,000 outpatient surgeries occur annually.² OHCA would have to collect, process, and house patient data related to these surgeries electronically. This will exceed current server and database limits, requiring a new server, database, and database administrator (including fringe benefits). Based on OHCA's current three-year hospital inpatient data processing contract, costs to process outpatient surgery patient records

¹ The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated non-pension fringe benefit cost associated with personnel changes is 23.76% of payroll in FY 12 and FY 13. In addition, there could be an impact to potential liability for the applicable state pension funds.

² There are approximately 181,000 hospital outpatient surgeries each year. It is unknown how many non-hospital surgeries occur annually. An additional 19,000 are assumed.

will be \$0.08 per patient record processed. These costs are detailed in the table below:

Item	FY 12 \$	FY 13 \$
1.0 Database Administrator	68,584	68,584
Server and software (one-time)	15,000	0
Data processing contract costs	16,000	16,000
Fringe Benefits	16,296	16,296
TOTAL	115,880	100,880

There is no cost to OHCA to permit the Comptroller to access this new data set.

The bill is not anticipated to result in a cost to the Comptroller or municipalities. As of October 1, 2011, the bill requires fully-insured municipalities to electronically submit information to the Comptroller's office regarding their employee and retiree health program. The bill requires insurers to submit the same information to the Comptroller for their municipal-sponsored policies. The Comptroller is able to specify the format in which the data will be submitted and therefore will use their existing software to compile the data submitted.

The bill also bestows additional duties on to the Comptroller which are not anticipated to result in a fiscal impact to the state. The Comptroller is able to absorb the additional functions including acting as a convener authority, and other analytic, administrative and reporting requirements within existing staff resources.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation. Pension-related costs for the identified personnel changes will be recognized in the state's annual required pension contribution as of FY 14.

In the out years, there may be potential savings to the state employee health plan and municipalities as a result of analyzing the

claims data, convening with the relevant entities specified in the bill, or by entering into cooperative agreements which provide incentives for efficiencies and improve health outcomes. To the extent that the Comptroller identifies potential payment and health delivery reforms or efficiencies which are implemented, the cost of providing health insurance to employees and retirees may decrease health care costs and potential savings may be achieved.

Sources: Office of Health Care Access

OLR Bill Analysis**sSB 1154*****AN ACT CONCERNING THE REPORTING OF CLAIMS INFORMATION TO THE COMPTROLLER AND ADDITIONAL DUTIES OF THE COMPTROLLER.*****SUMMARY:**

This bill:

1. establishes reporting requirements for (a) municipalities that sponsor fully-insured group health insurance policies or plans for their active employees and retirees and (b) insurers of these plans;
2. specifies the types of information these municipalities and insurers must annually submit, by October 1, to the comptroller regarding the policies or plans;
3. allows the comptroller to convene a group of stakeholders to develop and establish health care provider payment reforms for the group hospital, medical, and surgical health insurance plans under the state employee health plan;
4. expands the types of claims data hospitals must report to the Office of Healthcare Access (OHCA) and extends the reporting requirement to out-patient surgical facilities; and
5. requires OHCA to enter into a memorandum of understanding (MOU) with the comptroller to allow the comptroller access to this hospital and outpatient surgical facility claims data.

EFFECTIVE DATE: July 1, 2011

§ 1 — MUNICIPAL REPORTING REQUIREMENTS

The bill requires a municipality to electronically submit to the comptroller, in a form he prescribes, information for any fully-insured group health plan it sponsors covering (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; and (5) single-service ancillary health coverage plans, including dental, vision, and prescription drug plans.

For the immediately preceding policy or plan year, municipalities must provide a list of each type of health insurance policy or plan offered to its employees, early retirees, and retirees including:

1. covered benefits and any coverage limitations;
2. total premium costs for each policy or plan by coverage tier (e.g., single, two-person, and family), and each group's share of total premium cost;
3. cost sharing requirements (e.g., coinsurance, copayments, deductibles, and out-of-pocket expenses) associated with in-network and out-of-network providers; and
4. the value of any rebates or cost reductions a municipality receives for a prescription drug plan it offers.

They must also submit a list of the total number of employees, early retirees, and retirees in each policy or plan organized by (1) municipal department; (2) collective bargaining unit, if applicable; (3) coverage tier; and (4) active employee, early retiree, and retiree status.

For the two immediately preceding plan or policy years, municipalities must report the percentage increase or decrease in the policy or plan costs, calculated as the total premium costs. This calculation must include any premiums or contributions paid by active employees, early retirees, and retirees, divided by the total number of individuals the policy or plan covers. (The bill does not define "early retiree.")

The bill specifically prohibits a municipality from including health information (it does not define this) in its submission to the comptroller.

§ 2 — INSURER REPORTING REQUIREMENTS

Information An Insurer Must Disclose

The bill requires an insurer or similar entity to disclose to the comptroller the following information about its municipal-sponsored group insurance policy for each employer:

1. complete and accurate, medical, dental, and pharmaceutical utilization data as applicable and
2. total claims paid and claims paid by year, practice type, and service.

The information must be submitted electronically, in a form the comptroller prescribes, by October 1st annually. It must be for the immediately preceding policy year and include only information that (1) cannot be used to identify and individual and (2) is disclosable under the federal Health Insurance Portability and Accountability Act (HIPPA) or its regulations. The bill exempts information disclosed to the comptroller from disclosure under the Freedom of Information Act.

By law, an “employer” is a town; city; borough; or school, taxing, or fire district that has more than 50 employees.

Current law already requires an insurer or entity to disclose this and other claims data to a municipal employer upon request. The bill extends this disclosure requirement to an insurer or entity that delivers, issues, renews, amends, or continues any group health insurance policy in Connecticut that covers single-service ancillary health coverage plans, including dental, vision, and prescription drug plans. It already applies to plans that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

Reporting Requirement

The bill requires the comptroller to report by January 1, 2012, and annually thereafter, to the Appropriations, Insurance and Real Estate, Labor and Public Employees, and Planning and Development committees any estimated costs or savings for each employer whose information he received if the employer obtained health insurance coverage through a group hospital, medical, and surgical health insurance plan under the state employee health plan. (Current law does not allow an employer to do this. There are bills under consideration this session that would require the comptroller to offer coverage under the state employee health plan to non-state public employees and their retirees.)

Applicability

The bill applies to each insurer, HMO, hospital or medical service corporation, or other entity that delivers, issues, amends, or continues any municipal-sponsored group health insurance policy in Connecticut that covers (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; and (5) single-service ancillary health coverage plans, including dental, vision, and prescription drug plans.

§ 3 — CONVENOR AUTHORITY**Purpose**

The bill allows the comptroller, from July 1, 2011 until June 30, 2015, to convene a group of stakeholders to develop and establish health care provider payment reforms for the group hospital, medical, and surgical health insurance plans under the state employee health plan. Payment reforms may include multipayer initiatives, patient-centered medical homes, primary care case management, and value-based and bundled purchasing.

Members

Group members may include (1) insurers, HMOs, and hospital and medical service corporations; (2) third-party administrators providing

only administrative services to group hospital, medical, and surgical health insurance plans under the state employee health plan; (3) health care providers and facilities; (4) the Office of Policy and Management (OPM); and (5) state employees and retirees. Insurers and other entities are limited to those who issue, deliver, renew, amend, or continue group hospital, medical, and surgical health insurance plans under the state employee health plan. The bill specifies that participation in the group is voluntary.

Meetings and Surveys

The bill allows the comptroller or his designee to (1) survey the above entities and individuals about payment delivery reforms and (2) convene meetings at a convenient time and place for participants. It specifically prohibits anyone participating in a survey or meeting to solicit, share, or discuss pricing information.

It also provides that any survey or meeting is not (1) subject to disclosure under the Freedom of Information Act or (2) a violation of the Connecticut Antitrust Act.

Cooperative Agreements

The bill allows the comptroller enter into cooperative agreements with the above individuals or entities if he feels doing so will likely produce efficiencies and improvements in health care outcomes. The comptroller may enter into a cooperative agreement to (1) identify and reward high-quality, low-cost health care providers and (2) create enrollee incentives to (a) receive care from those providers and (b) promote personal health behaviors that will prevent or effectively manage chronic diseases, including tobacco cessation, weight control, and physical activity.

The comptroller may establish guidelines for these agreements, which must be consistent with federal antitrust laws and regulations.

Reporting Requirement

The bill requires the comptroller to report by January 1, 2016 to the Appropriations, Labor and Public Employees, and Public Health

committees on the effectiveness of his convenor authority, including the implementation of any cost containment measures or quality measurement or improvement initiatives and their associated cost savings or health outcomes.

§ 4 — OCHA CLAIMS DATA; MOU REQUIRED

The bill expands hospital data reporting requirements and applies them to outpatient surgical facilities. Current law requires acute care and children’s hospitals to submit to the Office of Health Care Access (OHCA-a division of the Department of Public Health) discharge data and any other data it requests to fulfill its responsibilities. The bill requires hospitals and outpatient surgical facilities to also submit inpatient and outpatient data.

It requires OHCA, by October 1, 2011, to enter into a memorandum of understanding with the comptroller to allow him access to this data if he agrees in writing to keep individual patient and physician data identified by name or personal identification code confidential.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Change of Reference
Yea 10 Nay 9 (03/17/2011)

Planning and Development Committee

Joint Favorable Change of Reference
Yea 18 Nay 1 (03/23/2011)

Public Health Committee

Joint Favorable Substitute
Yea 18 Nay 10 (04/01/2011)