Clerk of the House of Representatives	Secretary of the Senate
Legislative Resource Center	Office of Public Records
B-106 Cannon Building	232 Hart Building
Washington, DC 20515	Washington, DC 20510

Secretary of the Senate
Received: Aug 03, 2005

LOBBYING REPORT

Lobbying Disclosure Act of 1995 (Section 5) - **All Filers Are Required To Complete This Page**

1. Registrant Name:

MARSHFIELD CLINIC

2. Address:
1000 N OAK AVE, MARSHFIELD, WI 54449

3. Principal place of business (if different from line 2):

4. Contact Name: REED HALL
Telephone: 715-387-5511
E-mail (optional): hall.reed@marshfieldclinic.org

Senate ID #: 57830-12
House ID #: 35355000

7. Client Name: ☒ Self

TYPE OF REPORT

8. Year 2005 Midyear (January 1 - June 30): ☒ **OR** Year End (July 1 - December 31): ☐

9. Check if this filing amends a previously filed version of this report: ☐

10. Check if this is a Termination Report: ☐ => Termination Date: 11. No Lobbying Activity: ☐

INCOME OR EXPENSES

Complete Either Line 12 **OR** Line 13

12. Lobbying Firms

INCOME relating to lobbying activities for this reporting period was:

Less than $10,000: ☐

$10,000 or more: ☐ => Income (nearest $20,000): _____

Provide a good faith estimate, rounded to the nearest $20,000, of all lobbying related income from the client (including all payments to the registrant by any other entity for lobbying activities on behalf of the client).

13. Organizations

EXPENSES relating to lobbying activities for this reporting period were:

Less than $10,000: ☐

$10,000 or more: ☒ => Expenses (nearest $20,000): 190,405.00

14. Reporting Method.
Check box to indicate expense accounting method. See instructions for description of options.

☒ **Method A.** Reporting amounts using LDA definitions only
☐ **Method B.** Reporting amounts under section 6033(b)(8) of the Internal Revenue Code
☐ **Method C.** Reporting amounts under section 162(e) of the Internal Revenue Code

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: BUD (one per page)

16. Specific lobbying issues:

Provisions of the President's FY2006 Budget and related appropriations legislation (H Con Res 95, S Con Res 18) related to implementation of MMA, the provision of Medicare and Medicaid services and benefits to patients, incentives to promote electronic health records for all Americans, medical liability reform, prescription drug benefits. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations for 2006. Appropriations for Community Health Centers Appropriations for the Family Health Center to provide dental services Appropriations for rural telehealth grant programs in HRSA and HRSA rural health outreach grants. Appropriations for Laboratory Response Network in CDC. Appropriations for Personalized Medicine Research Programs in NIH. Appropriations for the Laird Center for Applied Sciences S 4, The Healthy America Act of 2005, To be introduced by Senator Bill Frist, (R-TN) calls for changes to make health care more affordable through medical liability reform, implementation of electronic health records, patient safety and voluntary error reporting; S 4 also expands access through tax deductions for the purchase of long term care insurance, and incentives for group purchasing arrangements for individuals; S 4 also strengthens the safety net by funding additional Community and Rural Health Centers, promoting chronic disease management, promoting care coordination by funding for integrated health systems, and expanding liability protection for health professionals who provide safety net services.

17. House(s) of Congress and Federal agencies contacted:
Centers For Medicare and Medicaid Services (CMS)
General Accounting Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: FOO (one per page)

16. Specific lobbying issues:

Development of governmental advice and consultation and research methods relevant to food safety services including but not limited to laboratory test development, topical research on genetics as well as zoonosis. Generally, Marshfield Clinic Laboratories' status relative to federal programs/initiatives in DHFS and USDA on the topics of CWD and Food Safety. Specifically investigation of: 1) USDA's determination that Marshfield Clinic Laboratories are not eligible to conduct certain kinds of tests which can at this point in time only be conducted by "federally-certified laboratories"; 2) the degree to which there exists a USDA "federal certification" process for laboratories; 3) feasibility of designating Marshfield Clinic Laboratories in a way so as to be "federally-certified" absent such a process in USDA for what it considers today to be "non-governmental" or "non-academic" laboratories; 4)processes for DHFS and USDA "recognition" of new, rapid testing scientific procedures as those "accepted" by USDA and FDA relative to their public health roles in food safety.

17. House(s) of Congress and Federal agencies contacted:
Agriculture, Dept of (USDA)
Food & Drug Administration (FDA)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: HCR (one per page)

16. Specific lobbying issues:

The Patient Safety and Quality Improvement Act of 2005 (S. 544) introduced by Sen. James Jeffords. This bill creates a new voluntary medical error reporting system, in which HHS would certify a number of private and public organizations to act as patient safety organizations. These PSOs would analyze data on medical errors, determine their causes, and develop and disseminate evidence-based information to providers to help them implement changes that would improve patient safety. To ensure reporting, data would be privileged against disclosure. Medical Liability The State of Wisconsin has successfully limited the escalation of liability insurance costs by implementing MICRA style medical liability reforms that include limits on non-economic damages, collateral source rules and limits on attorney's contingency fees. This proven mechanism for restraining liability insurance costs should be made widely available throughout the country. HR 534, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, introduced by Rep. Chris Cox in the House and S. 354 by Senator John Ensign in the Senate to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system. S. 306, the Genetic Information Nondiscrimination Act of 2005, introduced by Senator Olympia Snowe. And HR 1227 introduced by Rep. Judy Biggert in the House. Amends the Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code to prohibit health discrimination on the basis of genetic information or services. Defines genetic information as genetic tests of an individual or family member or occurrence of a disease or disorder in family members used to predict risk of disease in asymptomatic or undiagnosed individuals. Defines genetic services as health services provided for genetic education and counseling.

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: MED (one per page)

16. Specific lobbying issues:

HR 1175 Medical Laboratory Personnel Shortage Act of 2005 introduced by Rep. Schimkus- Amends the Public Health Service Act to require the Secretary of Health and Human Services (HHS), through scholarships and loans for health professional training that may be modeled after the National Health Service Corps' scholarship and loan repayment programs, to alleviate the shortage of medical laboratory personnel where needed. HR 2218 Medicare Laboratory Services Access Act of 2005 introduced by Rep English, Phil - Amends title XVIII (Medicare) of the Social Security Act (SSA) to specify as $5.78 for 2006, adjusted for inflation in each subsequent year, the nominal fee for collecting specimens for clinical diagnostic laboratory tests under Medicare. Oppose limits on the laboratory CPI update.

17. House(s) of Congress and Federal agencies contacted:
Centers For Medicare and Medicaid Services (CMS)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: MMM (one per page)

16. Specific lobbying issues:

Sustainable Growth Rate Medicare's SGR mechanism unfairly links physician payment updates to factors unrelated to patients' needs and the cost of providing patient care. If the SGR formula is not changed during the coming year, Medicare program trustees predict that Medicare physician payments will be cut by 31% between 2006-2013. Reform proposals include reimbursement updated on a market basket basis, removal of prescription drugs from the calculation of Medicare Part B costs, and rebasing Part B to reflect current rather than cumulative costs. S.1081, by Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI), the Preserving Patient Access to Physicians Act of 2005, would replace projected Medicare payment cuts with positive updates in each of the next two years. The bill would provide an update of not less than 2.7% in 2006 and an update in 2007 that reflects physician practice cost inflation, which is expected to be about 2.6%. H.R. 2356. Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD) A bill to amend title XVIII of the Social Security Act to reform the Medicare physician payment update system through repeal of the sustainable growth rate (SGR) payment update system. Pay-for performance Currently the prevailing methods of paying for health care in the US neither incent nor reward providing high quality care. The rising costs of care coupled with the increasing awareness of poor quality care have made clear the need for a transformation in the way health care is financed. In the fee-for-service system Medicare currently reimburses for units of service, in a manner that promotes service utilization without regard to quality. This has had the unanticipated, but now recognized effect of economically stimulating growth in the numbers of services provided by physicians. Medicare must implement quality based payments for physician services, and capture the data on performance measures utilizing available claims-based data recoverable through enhanced IT functions. S 1356, Introduced by Senators Chuck Grassley (R-IA) and Max Baucus (D-MT), the Medicare Value Purchasing Act, a bill that links physician payment to quality performance, increasing payment by 2% incrementally between 2008 and 2012, and funding the performance payments by drawing funds from physicians who do not report quality performance. Information Technology Under current law the capital and operating expenses of installing and maintaining an electronic medical record are assumed to be part of the overhead expense of a medical practice. Since no more than 5 ‖10% of the physician population has installed EMRs, CMS' measurement of current physician practice expenses reflect minimal expense associated with IT. Congress should provide incentives for EMR adoption, and should establish standards to facilitate the sharing and exchange of data. Payment Fairness The formulas by which Medicare's payments are calculated are widely variable throughout Medicare localities, and are based upon outdated data and assumptions regarding the cost and organization of medical practice. CMS must administratively revise its measurements of the costs of practice to assure the validity and fairness of payments. Payment Equity Before MMA 03, Medicare's payments were geographically adjusted based upon erroneous assumptions about the cost of hiring and retaining physicians. Congress established a floor payment mechanism for the physician work component of Medicare payment for '04 ‖ '06 to assure that physicians in low payment localities were compensated for their work at least at the national average payment amount. This payment floor should be extended indefinitely or geographic adjustment of work should be eliminated entirely. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 - Public Law No: 108-173 Title II: Medicare Advantage - Subtitle B: Immediate Improvements - (Sec. 211) Revises the payment system, requiring all plans to be paid at a rate at least as high as the rate for traditional Medicare fee-for-service plans. Makes change in budget neutrality for blended payments. Increases minimum percentage increase to national growth rate. Requires the Secretary to submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts on the availability on Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans. Subtitle C: Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition - (Sec. 221) Directs the Secretary to establish regional plans to encourage private plans to serve Medicare beneficiaries in from 10 to 50 regions, including in rural areas, within the 50 States and the District of Columbia beginning not later than January 1, 2005. Includes risk corridors for plans during the first two years of the program in 2006 and 2007; a stabilization fund to encourage plan entry and limit plan withdrawals; a blended benchmark that will allow plan bids to influence the benchmark amount; and network adequacy stabilization payments to assist plans in forming adequate networks, particularly in rural areas. Subtitle D: Additional Reforms - (Sec. 237) Provides that Federally Qualified Heatlh Centers (FQHCs) will receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. Raises reimbursements to FQHCs in order that when they are combined with MA payments and cost-sharing payments from beneficiaries they equal 100 percent of the reasonable costs of providing such services. Extends the safe harbor to include any remuneration between a FQHC (or entity controlled by an FQHC) and an MA organization. (Sec. 238) Requires the Secretary to enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation (for the Secretary and Congress) of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the Medicare program. Title III: Combatting Waste, Fraud, and Abuse - (Sec. 303) requires the Secretary, beginning in 2004, to make adjustments in practice expense relative value units for certain drug administration services when establishing the physician fee schedule; (2) require the Secretary to use the survey data submitted to the Secretary as of January 1, 2003, by a certain physician specialty organization; and (3) require the Secretary, beginning in 2005, to use supplemental survey data to adjust practice expense relative value units for certain drug administration services in the physician fee schedule if that supplemental survey data includes information on the expenses associated with administering drugs and biologicals the administration of drugs and biologicals, the survey meets criteria for acceptance, and the survey is submitted by March 1, 2004, for 2005, or March 1, 2005, for 2006. Title IV: Rural Provisions - Subtitle B: Provisions Relating to Part B Only - (Sec. 412) Directs the Secretary to increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00 for services furnished on or after January 1, 2004, and before January 1, 2007. (Sec. 413) Establishes a new five percent incentive payment program designed to reward both

primary care and specialist care physicians for furnishing physicians' services on or after January 1, 2005, and before January 1, 2008 in physician scarcity areas. Directs the Secretary to pay the current law ten percent Health Professional Shortage Area (HPSA) incentive payment for services furnished in full county primary care geographic area HPSAs automatically rather than having the physician identify the health professional shortage area involved. Directs the Comptroller General to conduct a study for a report to Congress on the differences in payment amounts under the Medicare physician fee schedule for physicians' services in different geographic areas. Subtitle D: (Sec. 432) Amends SSA title VII to expand the functions of the Office of Rural Health Policy to include administering grants, cooperative agreements, and contracts to provide technical assistance and other necessary activities to support activities related to improving health care in rural areas. Title VI: Provisions Relating to Part B - Subtitle A: Provisions Relating to Physicians' Services - (Sec. 605) Requires the Secretary to review and consider alternative data sources than those currently used to establish the geographic index for the practice expense component under the Medicare physician fee schedule no later than January 1, 2005. Requires the Secretary to select two physician payment localities for such purposes, one to be a rural area and the other one will be a statewide locality that includes both urban and rural areas. (Sec. 606) Directs the MEDPAC to submit to Congress: (1) a report on the effect of refinements to the practice expense component of payments for physicians' services after the transition to a full resource-based payment system in 2002; and (2) a report on the extent to which increases in the volume of physicians' services under Medicare part B are a result of care that improves the health and well-being of Medicare beneficiaries. Subtitle C: Other Provisions - (Sec. 626) Provides that in FY 2004, starting April 1, 2004, the ambulatory surgery center (ASC) update will be the Consumer Price Index for all urban consumers (U.S. city average) as estimated as of March 31, 2003, minus 3.0 percentage points. Provides that in FY 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the ASC update will be zero percent. Provides that upon implementation of the new ASC payment system, the Secretary will no longer be required to update ASC rates based on a survey of the actual audited costs incurred by a representative sample of ASCs every five years. Provides that subject to recommendations by the General Accounting Office, the Secretary will implement a revised payment system for payment of surgical services furnished in ASCs. Requires the new system to be implemented so that it is first effective on or after January 1, 2006, and not later than January 1, 2008. Requires the Comptroller General to conduct a study for a report to Congress that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments. (Sec. 628) Provides that there will be no updates to the clinical diagnostic laboratory test fee schedule for 2004 through 2008. Subtitle D: Additional Demonstrations, Studies, and Other Provisions - (Sec. 646) Amends SSA title XVIII to direct the Secretary to establish a 5-year demonstration program under which the Secretary is required to approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care. (Sec. 649) Directs the Secretary to establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures Title IX: Subtitle E: Miscellaneous Provisions - (Sec. 953) Requires the Comptroller General to report to Congress on: (1) the appropriateness of the updates in the conversion factor including the appropriateness of the sustainable growth rate formula for 2002 and subsequently. Requires the report to examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates; and (2) all aspects of physician compensation for services furnished under Medicare and how those aspects interact and the effect on appropriate compensation for physician services. Subtitle B: Miscellaneous (Sec. 1012) Directs the Secretary to establish the Commission on Systemic Interoperability to develop a comprehensive strategy for the adoption and implementation of health care information technology standards, that includes a timeline and prioritization for such adoption and implementation. Authorizes appropriations. Medicare Advisory Committee review of the scientific evidence pertaining to vertebroplasty and kyphoplasty. CMS Physician Group Practice Demonstration On September 27, 2002 the Centers for Medicare and Medicaid Services published a notice in the Federal Register informing interested parties of an opportunity to submit proposals for participation in the Medicare Physician Group Practice Demonstration (PGP) project to test a hybrid payment methodology that combines Medicare fee-for-service payments with a bonus pool derived from savings achieved by improvements in patient care management. Marshfield Clinic submitted a proposal for this demonstration and was selected by CMS to participate in the demonstration program, effective April 1 2005. Request for an advisory opinion regarding the "Stark Law" Section 1877(g)(6) of the Social Security Act and Sections 411.370 et seq. of Title 42 of the Code of Federal Regulations. Whether Marshfield Clinic's physician-shareholders have an ownership or investment interest in Marshfield Clinic for purposes of the Stark Law. On March 4, 2005 CMS published a proposed rule that would enable Competitive Acquisition of Outpatient Drugs and Biologicals Under Medicare Part B. The proposed rule would implement provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that require the implementation of a competitive acquisition program for certain Medicare Part B drugs not paid on a cost or prospective payment system basis. Beginning January 1, 2006, physicians will generally be given a choice between obtaining these drugs from vendors selected through a competitive bidding process or directly purchasing these drugs and being paid under the average sales price system. Oppose limits on the laboratory CPI update. On April 4, 2005, the HHS Secretary's Advisory Committee on Genetics, Health, and Society (SACGHS) published a Request for Public Comment in the Federal Register on a draft report on coverage and reimbursement of genetic tests and services. SACGHS is proposing to make the following recommendations: Medicare beneficiaries who lack current signs, symptoms, or personal histories of illness stand to clinically benefit from predictive and predispositional genetic tests and services. As such, SACGHS recommends that preventive services, including predispositional genetic tests and services, meeting evidence standards should be covered under Medicare. Reforming Medicaid Potential changes that will make Medicaid a more cost-effective and high quality program include the following: ·Prescription Drug Improvements. The goal of reducing both state and federal expenditures will require policy changes that impact all segments of the pharmaceutical marketplace, including increased rebates from manufacturers, reforms to the Average Wholesale Price (AWP), and tiered, enforceable co-pays for beneficiaries. · Asset Policy. Many individuals are utilizing Medicaid estate planners or other means in order to shelter or transfer assets and therefore qualify for Medicaid funded long-term care services. Medicaid reform must include changes that increase the penalties for inappropriate transfers, restrict the types of assets that can be transferred, and encourage reverse mortgages, as well as other policies that encourage individuals and their families to self-finance care rather than rely on Medicaid. · Cost Sharing. Medicaid's cost-sharing rules, which have not been updated since 1982, prevent states from utilizing market forces and personal responsibility to improve health care delivery. These provisions should be modified to make Medicaid look more like the State Children's Health Insurance Program (SCHIP), where states have broad discretion to establish enforceable premiums,

deductibles, or co-pays. · Benefit Package Flexibility. The Medicaid benefits package remains "one-size-fits-all." Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future. · Comprehensive Waiver Reforms. Reforms are needed to increase efficiency and reduce costs, increase the ease with which states obtain current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether. · Judicial Reforms. The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool.

17. House(s) of Congress and Federal agencies contacted:
Agency for Health Care Policy & Research
Centers For Medicare and Medicaid Services (CMS)
Congressional Budget Office (CBO)
General Accounting Office (GAO)
HOUSE OF REPRESENTATIVES
Health & Human Services, Dept of (HHS)
Health Resources & Services Administration (HRSA)
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

LOBBYING ACTIVITY.

Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Attach additional page(s) as needed.

15. General issue area code: TAX (one per page)

16. Specific lobbying issues:

According to the Joint Committee on Taxation, health-related organizations make up the largest percentage of Section 501(c)(3) non-profit organizations, accounting for almost 60 percent of total revenues of the 501(c)(3)s. Of the health-related organizations, hospitals constitute almost three-quarters of total revenues. Congress is looking at several issues: how the standards for tax-exemption evolved; what criteria are used to assess if organizations meet the tax-exempt standard; whether tax-exempt organizations operate principally as businesses selling their services in a competitive market.

17. House(s) of Congress and Federal agencies contacted:
HOUSE OF REPRESENTATIVES
SENATE

18. Name of each individual who acted as a lobbyist in this issue area:

Name: FARNSWORTH, KATHLEEN E.
Covered Official Position (if applicable): N/A
Name: MILLER, BRENT V.
Covered Official Position (if applicable): N/A
Name: NYCZ, GREG R.
Covered Official Position (if applicable): N/A

19. Interest of each foreign entity in the specific issues listed on line 16 above.**None**

Signature: ON FILE Date: Aug 03, 2005

Printed Name and Title: REED E. HALL - EXECUTIVE DIRECTOR