UNCORRECTED PROOF OF THE JOURNAL OF THE SENATE.

Thursday, March 30, 2000.

Met at twenty-five minutes before two o'clock P.M.

Distinguished Guests.

There being no objection, during the consideration of the Orders of the Day, the President introduced the Gloucester High School Distance Medley Team. At this year's New Balance National Scholastic Indoor Track Championships in New York City, the team set a new meet and American record. The team record broke the old record by more than eleven seconds and became the first high school team to run an indoor distance medley in less than ten minutes. The members of the team are Josh Palazola, Ngai Otieno, Shaun Milne and Tristan Colangelo. They were accompanied by their coach, Jim Munn, and were the guests of Senator Tarr.

Committee Discharged.

Ms. Melconian, for the committees on Rules of the two branches, acting concurrently, reported, asking to be discharged from further consideration

Of the Senate Order relative to authorizing the joint committee on the Judiciary to sit during the recess of the General Court for the purpose of making an investigation and study of Senate documents numbered 2111 and 2126 (Senate, No. 2145); and

Of the Senate Order relative to authorizing the joint committee on Natural Resources and Agriculture to sit during the recess of the General Court for the purpose of making an investigation and study of Senate document numbered 1016, relative to Massachusetts Water Resources Authority rates (Senate, No. 2153);
And recommending that the same severally be referred to the Senate committee on Rules.
Under Senate Rule 36, the reports were severally considered forthwith and accepted.

PAPER FROM THE HOUSE.

Notice was received that the Speaker had announced the appointment of Representatives Chandler of Worcester and Pope of Wayland to serve on the special commission established (under Section 344 of Chapter 127 of the Acts of 1999) to study the present and future health of acute care hospitals in the Commonwealth.

The Speaker also announced the appointment of Representatives Ciampa of Somerville, Candaras of Wilbraham, Malia of Boston, Merrigan of Greenfield and Pope of Wayland to serve on the advisory council established (under Section 379 of Chapter 194 of the Acts of 1998) on Alzheimer's disease.

Orders of the Day.

The Orders of the Day were considered, as follows:

Bills

Designating Robert L. Pais as a permanently disabled police officer (Senate, No. 1241);

Relative to inspecting and securing unsafe or abandoned buildings (Senate, No. 2095);

Authorizing the town of Andover to enter into certain agreements and to convey and accept certain interest in real estate (Senate, No. 2097);

Relative to gifts of personal property to municipalities (House, No. 824); and

Relative to the use of the subdivision forfeiture account in the town of Billerica (House, No. 4484, changed);
Were severally read a second time and ordered to a third reading.

The Senate bills

Regarding registered nurse first assistants (Senate, No. 2154);

Requiring insurance coverage for certain hormone replacement therapy and outpatient contraceptive services (Senate, No. 2155) (its title having been changed by the committee on Bills in the Third Reading); and

Relative to the game of Beano (Senate, No. 2156);
Were severally read a third time and passed to be engrossed.
Severally sent to the House for concurrence.

The House bills

Authorizing the establishment of the Lawrence municipal airport enterprise commission (House, No. 1269, amended);

Authorizing the city of Quincy to grant certain easements (House, No. 4284); and

Relative to appropriations after certain municipal ballot questions (House, No. 4551) (its title having been changed by the committee on Bills in the Third Reading);
Were severally read a third time and passed to be engrossed, in concurrence.

The House Bill relative to underage drinking (House, No. 4506, amended),— **was read a third time and passed to be engrossed, in concurrence.**
Sent to the House for concurrence in the amendments previously adopted by the Senate.

The Senate Bill further defining the practice of mental health counseling (Senate, No. 609),— was read third time.
Pending the question on passing the bill to be engrossed, Ms. Murray moved that the bill be amended by striking out, in line 16, the word “assessment,”; and by adding the following paragraph:—
“Practice of mental health counseling in independent practice with individuals diagnosed with psychosis may be undertaken by a licensed mental health counselor: (a) who is licensed under section 165 on or after March 1, 1992; or (b) who is licensed prior to March 1, 1992 and who meets the certification criteria for independent practice with individuals diagnosed with psychosis as established by the board of registration of allied mental health and human services professions.”.
This amendment was adopted.
The bill (Senate, No. 2166, printed as amended) was then passed to be engrossed.

Sent to the House for concurrence.

The House Bill relative to life insurance company liquidation proceedings (House, No. 4852),— was read third time.
Pending the question on passing the bill to be engrossed, Mr. Bernstein moved that the bill be amended by striking out all after the enacting clause and inserting in place thereof the text of Senate document numbered 2163.
This amendment was adopted.
The bill was then passed to be engrossed, in concurrence, with the amendment.
Sent to the House for concurrence in the amendment.

The Senate Bill relative to certain tobacco manufacturers (Senate, No. 2157) (its title having been changed by the committee on Bills in the Third Reading),— **was read a third time; and, after remarks, was passed to be engrossed.**

Sent to the House for concurrence.

The House Bill requiring competent interpreter services in the delivery of acute health care services (House, No. 4917, amended),— was read a third time.

Pending the question on passing the bill to be engrossed, Messrs. Montigny and Travaglini moved that the bill be further amended in section 6 (as amended by the Senate), by striking out the word "January" and inserting in place thereof the following word:— "July".
This amendment was adopted.
After remarks, the question on passing the bill to be engrossed, in concurrence, was determined by a call of the yeas and nays, at fourteen minutes past two o'clock P.M., on motion of Mr. Moore, as follows, to wit (yeas 38 — nays 0):

YEAS.

Antonioni, Robert A.	Fargo, Susan C.
Bernstein, Robert A.	Glodis, Guy W.
Berry, Frederick E.	Havern, Robert A.
Brewer, Stephen M.	Hedlund, Robert L.
Clancy, Edward J., Jr.	Jacques, Cheryl A.
Creedon, Robert S., Jr.	Jajuga, James P.
Creem, Cynthia Stone	Joyce, Brian A.
Knapik, Michael R.	Rauschenbach, Henri S.
Lees, Brian P.	Resor, Pamela
Magnani, David P.	Rosenberg, Stanley C.
Melconian, Linda J.	Shannon, Charles E.
Menard, Joan M.	Sprague, Jo Ann
Montigny, Mark C.	Tarr, Bruce E.
Moore, Richard T.	Tisei, Richard R.
Morrissey, Michael W.	Tolman, Steven A.
Murray, Therese	Travaglini, Robert E.
Nuciforo, Andrea F., Jr.	Tucker, Susan C.
Pacheco, Marc R.	Walsh, Marian
Panagiotakos, Steven C.	Wilkerson, Dianne — 38.

NAYS — 0.

ABSENT OR NOT VOTING.

Lynch, Stephen F. — 1.

The yeas and nays having been completed at nineteen minutes past two o'clock P.M., the bill was passed to be engrossed, in concurrence, with the amendments.
Sent to the House for concurrence in the amendments adopted by the Senate.

The House Bill relative to nongroup health insurance (House, No. 4993, printed as amended),— was read a third time.
Messrs. Tarr, Lees, Knapik, Tisei, Hedlund, Mrs. Sprague and Mr. Rauschenbach moved that the bill be further amended by striking out section 5 and inserting in place thereof the following section:—
"SECTION 5. Said section 1 of said chapter 176M, as so appearing, is hereby amended by striking out the definition of 'health plan' and inserting in place thereof the following definition:—
'Health plan,' any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other jurisdiction; a hospital service plan issued by a non-profit hospital service corporation pursuant to chapter 176A or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued pursuant to chapter 176I or the laws of any other jurisdiction. The words 'health plan' shall not include accident only, credit or dental insurance, short term limited duration insurance, hospital indemnity insurance policies which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $250 per day, as adjusted on an annual basis by the amount of increase in the average weekly wage in the commonwealth as defined in chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of an insured or a dependent, or disability income insurance issued as a supplement to liability insurance,

insurance arising out of a worker's compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long term care only insurance, or any policy subject to the provision of chapter 176K. The commissioner may by regulation define other health coverage as a health plan for the purposed of this chapter."; and by inserting after section 7 the following section:—

"SECTION 7A. Said section 1 of said chapter 176M, as so appearing, is hereby further amended by inserting after the definition of 'Resident' the following definition:—

'Short-term limited duration insurance,' insurance provided pursuant to a contract with a carrier that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's consent, that is within 12 months of the date such contract becomes effective.".

After debate, Ms. Melconian in the Chair, the question on adoption of the amendment was determined by a call of the yeas and nays, at four minutes before three o'clock P.M., on motion of Mr. Lees, as follows, to wit (yeas 11 — nays 27):

YEAS.

Brewer, Stephen M.
Glodis, Guy W.
Hedlund, Robert L.
Knapik, Michael R.
Lees, Brian P.
Menard, Joan M.
Moore, Richard T.
Rauschenbach, Henri S.
Sprague, Jo Ann
Tarr, Bruce E.
Tisei, Richard R. — 11.

NAYS.

Antonioni, Robert A.
Bernstein, Robert A.
Berry, Frederick E.
Clancy, Edward J., Jr.
Creedon, Robert S., Jr.
Creem, Cynthia Stone
Fargo, Susan C.
Havern, Robert A.
Jacques, Cheryl A.
Jajuga, James P.
Joyce, Brian A.
Magnani, David P.
Melconian, Linda J.
Montigny, Mark C.
Morrissey, Michael W.
Murray, Therese
Nuciforo, Andrea F., Jr.
Pacheco, Marc R.
Panagiotakos, Steven C.
Resor, Pamela
Rosenberg, Stanley C.
Shannon, Charles E.
Tolman, Steven A.
Travaglini, Robert E.
Tucker, Susan C.
Walsh, Marian
Wilkerson, Dianne — 27.

ABSENT OR NOT VOTING.

Lynch, Stephen F. — 1.

The yeas and nays having been completed at three o'clock P.M., the amendment was *rejected.*

Messrs. Tarr, Rauschenbach and Knapik moved to amend the bill by inserting after section 16 the following section:—

"SECTION 16A. Chapter 176M is hereby further amended by adding the following six sections:—

Section 7. For purposes of sections 7 to 7F, inclusive, the following words shall have the following meanings:

'Carrier', an insurer licensed or otherwise authorized to transact accident and health benefit plans under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and any multiple employer welfare arrangement

(MEWA) required to be licensed under chapter 175, that issues a health benefit plan on or after January 1, 1997.
'Commissioner', the commissioner of the division of insurance or his designee.
'Eligible dependent', the spouse or children of an eligible individual and who also meets all of the criteria in the term 'eligible individual', as defined in section 1.
'Eligible individual', a resident of the commonwealth who meets all of the following criteria: a) the individual is not insured under any other health benefit plan, including a guaranteed-issue individual health plan, as defined under Section 3, or any individual policy of insurance issued pursuant to a conversion privilege contained in any group or individual policy; b) the individual does not have access to a health benefit plan through such individual's employer, either because the employer does not offer a health benefit plan or because the employee does not meet the eligibility criteria under such health benefit plan including the criteria for an eligible employee set forth in chapter one hundred and seventy-six J; c) none of the premium for the individual's health benefit plan, whether issued on a group or non-group basis, is paid directly or indirectly by such individual's employer; d) the individual is not eligible for coverage through a health benefit plan in which such individual's spouse or parent or guardian is enrolled or eligible to be enrolled; e) such individual is not eligible to obtain benefits through a health benefit plan program administered directly or indirectly by the department under chapter one hundred and eighteen F; f) the individual is not or is no longer eligible for continued group coverage under section 4980B of the Internal Revenue Code of 1986, section 601 through 608 of the Employee Retirement Income Security Act of 1974, or pursuant to sections 2201 through 2208 of the Public Health Service Act, as amended; and g) the individual is not eligible for continuation of coverage health benefits under chapter 110D, chapter 110G or chapter 110I of chapter 175 of the Massachusetts General Laws; h) the individual is not eligible for health benefits funded and administered by any other Commonwealth or federal government program. For the purpose of subsection (f) above, an individual who would have been eligible for such continuation of coverage benefits, but is not eligible solely because such individual failed to make the required coverage election during the applicable time period or failed to make the required premium payment, shall be deemed to be eligible for such group coverage until the date on which the individual's continuing group coverage benefits would have expired had an election or premium payment been made.
(e) 'Emergency Services', covered services provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in: 1) placing the patient's health in serious jeopardy; 2) serious impairment of bodily functions; or, 3) serious dysfunction of any bodily organ or part.
(f) 'Guaranteed-issue individual health plan', shall have the meaning as defined in Section 3 of this Amendment.
(g) 'Health benefit plan', any blanket, general or group policy or medical, surgical or hospital insurance described in subsections (a), (c) or (d) of section one hundred and ten of chapter one hundred and seventy-five, any policy of accident or sickness insurance as described in section one hundred and eight of chapter one hundred and seventy-five which provides hospital or surgical expense coverage; any non-group or group hospital or medical service plan issued by a non-profit hospital or medical service corporation under chapters one hundred and seventy-six A and one hundred and seventy-six B; any nongroup or group health maintenance contract issued by a health maintenance organization under chapter one hundred and seventy-six C; any self-insured or self-funded employer group health plan; any health coverage provided to persons serving in the armed forces of the United Commonwealths; or medical assistance provided under chapter one hundred and eighteen E; the term 'health benefit plan' shall not include accident only, credit, dental or disability income insurance, any individual policy of insurance issued pursuant to a conversion privilege contained in any group or individual policy, supplemental hospital indemnity coverage sold on a per diem basis, specified disease coverage, coverage issued as a supplement to liability insurance, insurance arising out of a worker's compensation or similar law, automobile medical payment insurance, insurance under which beneficiaries are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance, long-term care insurance, nursing home insurance, home health care insurance or any group blanket or governmental program or health benefit plans coverage issued to a student in compliance with section eighteen of chapter fifteen A of the General Laws of Massachusetts. The commissioner may, by regulation, define other health coverage as an eligible plan for the purposes of this chapter.
(h) 'Massachusetts Health Plan Partnership, Inc.', known as 'The Partnership,' shall have the meaning as defined in Section 2 of this Amendment.
(i) 'Pre-Existing Condition Provision', a health benefit plan provision which excludes coverage for charges or expenses incurred during a specified period following the effective date of coverage (i) as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received or (ii) as to a pregnancy existing on the effective date of coverage.
(j) 'Qualifying health benefit plan', (i) any blanket, general or group policy of medical, surgical or hospital insurance described in subsections (A), (C) or (D) of section one hundred and ten of chapter one hundred and seventy-five; (ii) any policy of accident or sickness insurance as described in section one hundred and eight of chapter one hundred and seventy-five which provides hospital or surgical expense coverage; (iii) any non-group or group hospital or medical service plan issued by a non-profit hospital or medical service plan issued by a non-profit hospital or medical service corporation under chapters one hundred and seventy-six A and one hundred and seventy-six B; (iv) any non-group or group health maintenance contract issued by a health maintenance organization under chapter one hundred and seventy six G; (v) any self-insured or self-funded employer group health plan; (vi) any health coverage provided to persons serving in the armed forces of the United States; or (vii) medical assistance provided under chapter one hundred and eighteen E. The commissioner may, by regulation, define other health coverage as a qualifying health plan for the purposes of this chapter.

(k) ‘Resident’, a person living in this Commonwealth, as defined by the commissioner by regulation; provided, however, that the person has lived in the commonwealth for not less than six months prior to application for enrollment in the health benefit plans under this chapter and the person did not move into the commonwealth for the sole purpose of securing health benefit plans under this chapter; and provided further, that confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such a person as a resident.
(1) ‘Waiting period’, a period immediately subsequent to the effective date of coverage under a health benefit plan during which the carrier does not pay for some or all hospital or medical expenses.
Section 2. There is hereby created a nonprofit legal entity to be known as the Massachusetts Health Plan Partnership, Inc. (hereafter referred to as ‘The Partnership’). All carriers doing business in the commonwealth as a condition to their authority to transact the applicable kinds of health benefit plans defined in Section 1 of this chapter, shall be members of ‘The Partnership.’ ‘The Partnership’ shall perform its functions under a plan of operation established and approved under subdivision (a), and shall exercise its powers through a board of directors established under this section.
(a)(1) The board of directors of ‘The Partnership’ shall be made up of nine individuals selected by members, subject to approval by the governor, to select the initial board of directors and to initially organize ‘The Partnership.’ The governor shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based on the net health benefit plans premium derived from this commonwealth in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the governor may appoint the initial board. In approving or selecting members of the board, the governor may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the monies of ‘The Partnership’ for expenses incurred by them as members, but shall not otherwise be compensated by ‘The Partnership.’ The plan of operation shall become effective upon approval in writing by the governor consistent with the date on which the ‘Guaranteed-issue individual health plan’ coverage under Section 3 of this Amendment must be made available. The governor shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of ‘The Partnership,’ and provides for the sharing of ‘The Partnership’ gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the governor shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the governor. The plan of operation shall, in addition to requirements enumerated in Sections 1 through 5 inclusive: (A) Establish procedures for the handling and accounting of assets and monies of ‘The Partnership’; (B) establish regular times and places for meeting of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D) establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administering carrier and set forth the provisions necessary or proper for the execution of the powers and duties of ‘The Partnership’; (H) establish procedures for the advertisement of the general availability of the ‘Guaranteed-issue individual health plan’ under Sections 1 through 5 of this Amendment, inclusive; and (I) establish an actuarial committee consisting of five persons who are members of the American Academy of Actuaries.
‘The Partnership’ shall have the general powers and authority granted under the laws of this commonwealth to carriers to transact the kinds of insurance defined under ‘health benefit plan’ in Section 1 of this Amendment, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of Sections 1 through 5, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members; (3) take such legal action necessary to avoid the payment of improper claims against ‘The Partnership’ or the coverage provided by or through ‘The Partnership’; (4) establish, with respect to health benefit plans provided by or on behalf of ‘The Partnership,’ appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided by carriers outside ‘The Partnership’ that are not offered through a managed care delivery system, appropriate rates, scales of rates, rate classifications and rating adjustments; (6) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of ‘The Partnership,’ policy and contract design, and any other function within the authority of ‘The Partnership.’
Every member shall participate in ‘The Partnership’ in accordance with the provisions of this subdivision (1). Rates for coverage issued by or through ‘The Partnership’ shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age and geographic area shall apply. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for ‘The Partnership’ risks and reimbursement of reasonable expenses incurred for the writing of ‘The Partnership’ risks. In no event shall the rate for a given individual or an individual with family coverage be less than one hundred twenty-five percent or more than one hundred fifty percent of the rate charged an individual or an individual with family coverage who would be issued a policy at a so-called standard non-group rate. All rates promulgated by ‘The Partnership’ shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate, or unfairly discriminatory.
Following the close of each calendar year, the administering carrier shall determine the new premiums earned, the incurred losses for the year and the expenses of administering ‘The Partnership.’ Any net loss shall be assessed to all members in proportion to their respective shares of the total health benefit plans premiums earned in this commonwealth during the calendar year. All members who offer a ‘Guaranteed-issue individual health plan,’ as defined in Section 3 of this Amendment, shall be eligible to

reduce their respective shares of the total health benefit plans premiums by the amount of premium earned from such 'Guaranteed-issue individual health plans.'

'The Partnership' shall conduct periodic audits to assure the general accuracy of the financial data submitted to 'The Partnership' and 'The Partnership' shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review.

Every 'Guaranteed-issue individual health plan' issued or renewed through the Massachusetts Health Plan Partnership, Inc., shall provide benefits through a managed care delivery system. Such managed care delivery system shall include one or more health maintenance organization or preferred provider network plans, as determined by the board of 'The Partnership,' with the approval of the commissioner. In the event that such managed care plans would not adequately serve enrollees in a particular area of the commonwealth, the board may offer to such enrollees a managed care product which contains alternative cost containment features, including but not limited to, utilization review of health care services, review of the medical necessity of hospital and physician services and case management benefit alternatives. Nothing herein shall require carriers offering a 'Guarantee-issue individual health plan' outside 'The Partnership' to provide benefits through a managed care delivery system.

All policy forms issued by a carrier shall conform in substance to prototype forms developed by 'The Partnership', shall in all other respects conform to the requirements of Sections 1 through 5 inclusive, and shall be certified and filed for informational purposes with the commissioner.

Neither 'The Partnership' nor a carrier shall issue a 'Guaranteed-issue individual health plan' to someone who is not an eligible individual or an eligible dependent.

There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, 'The Partnership' or its agents or its employees or the commissioner or his or her representatives for any action taken by them in the performance of their duties under Sections 1 through 5, inclusive. This provision shall not apply to the obligations of a carrier or 'The Partnership' for payment of benefits provided under a 'Guaranteed-issue individual health plan.'

Section 3. All 'Guaranteed-issue individual health plans' shall include minimum standard benefits and coverage provisions as described in this section.

(A) A 'Guaranteed-issue individual health plan' shall be a uniform set of benefits specified by the commissioner in regulation which shall include at least the following medically necessary services: reasonably comprehensive physician services; inpatient and outpatient hospital services; emergency health care services; and a full range of effective clinical preventive care. The commissioner may require the carrier to offer additional medical treatments, procedures and related health services consistent with MGL Chapter 175 and any other stationary provisions.

(B) A 'Guaranteed-issue individual health plan' offered by 'The Partnership' or a carrier may contain alternative policy provisions and benefits, including cost containment features, consistent with the purposes of this chapter, provided such alternative provisions and benefits are approved by the insurance commissioner prior to their use.

(C)(1) No 'Guaranteed-issue individual health plan' shall exclude any eligible individual or eligible dependent on the basis of age, occupation, the actual or expected health condition of such person, or the claims experience or medical condition of such person; (2) Every 'Guaranteed-issue individual health plan' shall be renewable with respect to all eligible individuals and eligible dependents at the option of the eligible individual except in instances where: (i) the individual repeatedly failed to pay the required premium on a timely basis, or (ii) the individual committed fraud, or misrepresented whether or not he or she qualifies as an eligible individual or eligible dependent, or (iii) the individual failed to comply in a material way with the provisions of the health benefit plan; (3) Preexisting conditions provisions shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to (i) conditions which had, during the six months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during such period or (ii) a pregnancy existing on the effective date of coverage.

In determining whether a preexisting condition provision applies to an eligible individual, all 'Guaranteed-issue individual health plans' shall credit the time such person was covered under a previous qualifying health benefit plan if the previous coverage was continuous to a date not more that thirty days prior to the effective date of the new coverage, and if the previous qualifying health benefit plan coverage was reasonably actuarially equivalent to the new coverage; (iii) No 'Guaranteed-issue individual health plan' shall provide for a waiting period of more than six months beyond the eligible individual's effective date of coverage under the 'Guaranteed-issue individual health plan.' If the 'Guaranteed-issue individual health plan' includes a waiting period, emergency services must be covered during the waiting period. In applying a waiting period to an eligible individual, all 'Guaranteed-issue individual health plans' shall credit the time such person was covered under a previous qualifying health benefit plan if such person experiences only a temporary interruption in coverage.

Section 4. (A) Every carrier offering a health benefit plan to individuals in the commonwealth shall elect annually for the calendar year to either (i) offer a 'Guaranteed-issue individual health plan,' described in Section 3, to every eligible individual in the commonwealth, or (ii) not offer a 'Guaranteed-issue individual health plan.'

(B) Every carrier that elects to offer the 'Guaranteed-issue individual health plan' may also offer health benefit plans other than the 'Guaranteed-issue individual health plan' so long as the plans' benefit design and rates conform with that carrier's governing statute and applicable regulation.

(C) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible dependent if (1) the eligible individual or eligible dependent does not meet a health maintenance organization's requirements regarding residence within the health maintenance organization's approved service area; or (2) within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not, within that area, have the

capacity in its network of providers to deliver services adequately to the individual because of its obligations to existing contract holders and enrollees; provided that the health maintenance organization that demonstrates to the satisfaction of the applicants for coverage, whether they be applicants for group or non-group coverage, until the later of ninety days after each such refusal or the date on which the health maintenance organization notifies the commissioner that it has regained capacity to deliver services to eligible individuals and eligible dependents.
(D) The premium charged for a 'Guaranteed-issue individual health plan' which is not issued by or through 'The Partnership' may not exceed the premium which would be applicable for such eligible individual if such plan was issued by 'The Partnership.' The premium may not exceed the premium established under 'The Partnership.'
(E) The carrier may reserve the right to adjust premiums by classes in accordance with its experiences for 'Guaranteed-issue individual health plan,' provided such premium may not exceed the premium established for that particular class by 'The Partnership.'
Section 5. A 'Guaranteed-issue individual health plan' shall contain the minimum standard benefits prescribed in Section 3 and shall also conform in substance to the requirements of this section. Each 'Guaranteed-issue individual health plan' shall contain provisions: (1) Which obligate the carrier to continue the contract until the earlier of (A) the date on which the individual whose name the contract was issued first becomes eligible for coverage under Title XVIII of the Social Security Act, provided the individual is sixty-five years of age or older, or under a group health benefit plan, or (B) the plan anniversary date at least sixty days prior to which the carrier has mailed to the individual at his last address shown on the carrier's records written notice of its decision not to continue coverage on a class basis only, or (C) the date on which the individual becomes eligible for coverage under a health benefit plan, a high risk pool or arrangement established by statute or regulation in another state; (2) which, upon the death of the individual in whose name to contract was issued, permits every other individual then covered under the contract to elect, within such a period as shall be specified in the contract, to continue the same coverage until such time as he would have ceased to be entitled to coverage had the individual in whose name the contract was issued lived; and (3) under which the benefits payable shall be excess to all other sources of health benefit plans benefits including benefits provided pursuant to any commonwealth or federal law other than Medicaid.
Section 6. A carrier may meet it's requirements subsequent to subsection (b)(1) of Section 2 of Chapter 176M of the General Laws by participating in 'The Partnership' as established in Section 2 of this Amendment.".
After debate, the amendment was *rejected*.

Messrs. Rauschenbach, Lees, Tarr, Hedlund and Knapik, Mrs. Sprague, and Mr. Tisei moved to amend the bill by striking out section 12 and inserting in place thereof the following section:
"SECTION 12. Said Section 3 of said chapter 176M, as so appearing, is hereby further amended by striking out subsection (d) and inserting in place thereof the following subsection:
(d) all carriers with closed plans may, pursuant to their underwriting guidelines, enroll individuals into said closed plans. A carrier shall maintain a closed plan until no subscribers are enrolled in said plan. A carrier may permit a subscriber to renew a closed plan. A carrier shall file its rates for a closed plan in accordance with subsection (a) of Section 5. A closed plan shall not otherwise be subject to the requirements of Section 5. A closed plan shall not be subject to the requirements of Section 4. No carrier shall add any new rating factor to the rating methodology which was applicable to its closed plan as of August 15, 1996. Nothing in this Section shall prohibit a subscriber from enrolling in a guaranteed issue plan; provided the subscriber meets the requirements of this chapter."
After debate, the President in the Chair, the amendment was *rejected*.
The bill was then passed to be engrossed, in concurrence.
Sent to the House for concurrence in the amendment previously adopted by the Senate.

The Senate Bill simplifying the approval of certain subdivisions (Senate, No. 1842),— was considered.
Pending the question on laying the bill on the table, and pending the main question on passing the bill to be engrossed, on motion of Mr. Lees, the further consideration thereof was postponed until Thursday, April 6.

Resolutions.

The following resolutions (having been filed with the Clerk) were considered forthwith; and, after remarks, were adopted, as follows:—
Resolutions (filed by Mr. Montigny) "forecasting the amount of tax revenue for fiscal year 2001."

Engrossed Bill — Land Taking for Conservation, Etc.

An engrossed Bill authorizing the city of Lawrence to use certain park and playground land for school purposes (see House, No. 4380) (which originated in the House), having been certified by the Senate Clerk to be rightly and truly prepared for final passage,— was put upon its final passage; and, this being a bill providing for the taking of land or other easements used for conservation purposes, etc., as defined by Article XCVII of the Amendments to the Constitution, the question on passing it to be enacted was determined by a call of the yeas and nays, at eleven minutes before four o'clock P.M., as follows, to wit (yeas 38 — nays 0):

YEAS.

Antonioni, Robert A.	Fargo, Susan C.
Bernstein, Robert A.	Glodis, Guy W.
Berry, Frederick E.	Havern, Robert A.
Brewer, Stephen M.	Hedlund, Robert L.
Clancy, Edward J., Jr.	Jacques, Cheryl A.
Creedon, Robert S., Jr.	Jajuga, James P.
Creem, Cynthia Stone	Joyce, Brian A.
Knapik, Michael R.	Rauschenbach, Henri S.
Lees, Brian P.	Resor, Pamela
Magnani, David P.	Rosenberg, Stanley C.
Melconian, Linda J.	Shannon, Charles E.
Menard, Joan M.	Sprague, Jo Ann
Montigny, Mark C.	Tarr, Bruce E.
Moore, Richard T.	Tisei, Richard R.
Morrissey, Michael W.	Tolman, Steven A.
Murray, Therese	Travaglini, Robert E.
Nuciforo, Andrea F., Jr.	Tucker, Susan C.
Pacheco, Marc R.	Walsh, Marian
Panagiotakos, Steven C.	Wilkerson, Dianne — 38.

NAYS — 0.

ABSENT OR NOT VOTING.

Lynch, Stephen F. — 1.

Ms. Melconian in the Chair (having been appointed by the President, under authority conferred by Senate Rule 4, to perform the duties of the Chair), the yeas and nays having been completed at six minutes before four o'clock P.M., the bill was passed to be enacted, two-thirds of the members present having agreed to pass the same, and it was signed by the Acting President and laid before the Governor for his approbation.

Matters Taken Out of the Notice Section of the Calendar.

There being no objection, the following matter were taken out of the notice section of the Calendar and considered, as follows:

The House bills

Relative to certain positions in the town of North Attleborough (House, No. 533); and
Authorizing the town of Stow to release a certain conservation restriction (House, No. 5053, changed);
Were severally read a second time, ordered to a third reading, read a third time and passed to be engrossed, in concurrence.

Resolutions.

The following resolutions (having been filed with the Clerk) were severally considered forthwith and adopted, as follows:—

Resolutions (filed by Mr. Creedon) "congratulating Mario 'Duke' Moretti on the occasion of his retirement from the East Bridgewater Police Department";
Resolutions (filed by Mr. Pacheco) "honoring Walter F. Earl";
Resolutions (filed by Mr. Shannon) "honoring Thomas J. Kelly on the occasion of his retirement";
Resolutions (filed by Mr. Shannon) "congratulating Edward O'Connell";

Resolutions (filed by Mr. Tisei) “commending Ann E. Hadley”;
Resolutions (filed by Mr. Tolman) “honoring the seventy-fifth anniversary of the Watertown Rotary Club”;
Resolutions (filed by Ms. Walsh, Ms. Tucker, Ms. Menard, Messrs. Rauschenbach, Tisei and Joyce, Ms. Murray and Mr. Clancy) “recognizing and honoring the residents of the Commonwealth who served and died in the Persian Gulf War”; and
Resolutions (filed by Ms. Wilkerson)“honoring Dorothy ‘Dottie’ Jackson”.

PAPERS FROM THE HOUSE.

Petitions were referred, in concurrence, as follows:

Petition (accompanied by bill, House, No. 5091) of Vincent P. Ciampa and other members of the General Court for legislation to provide office space within the Office of Veterans’ Services for use by the American Gold Star Mothers and the American Gold Star Wives;
Under suspension of Joint Rule 12, to the committee on Human Services and Elderly Affairs.

Petition (accompanied by bill, House, No. 5092) of Charles A. Murphy, Kevin L. Finnegan, Steven C. Panagiotakos and another relative to increases in the amounts of homestead protection;
Under suspension of Joint Rule 12, to the committee on the Judiciary.

Engrossed Bills.

The following engrossed bills (the first of which originated in the Senate), having been certified by the Senate Clerk to be rightly and truly prepared for final passage, were severally passed to be enacted and were signed by the Acting President and laid before the Governor for his approbation, to wit:

Designating an official Korean War Memorial for the Commonwealth (see Senate, No. 1410); and

Relative to the office of Register of Deeds of Barnstable County (see House, No. 4827).

Order Adopted.

On motion of Mr. Rosenberg,—
Ordered, That when the Senate adjourns today, it adjourn to meet again on Monday next at eleven o’clock A.M., and that the Clerk be directed to dispense with the printing of a calendar.

On motion of Mr. Lees, at two minutes before four o’clock P.M., the Senate adjourned to meet on the following Monday at eleven o’clock A.M.