UNCORRECTED PROOF OF THE JOURNAL OF THE SENATE.

JOURNAL OF THE SENATE.

Wednesday, November 9, 2005.

Met at ten minutes past one o'clock P.M. (Ms. Walsh in the Chair).

Petitions.

Petitions were presented and referred, as follows:

By Mr. Baddonr, a petition (subject to Joint Rule 12) of Steven A. Baddour, Robert A. Havern, Martin J. Walsh, Michael R. Knapik and others for legislation to establish the Commonwealth turnaround collaborative to improve school performance;

By Mr. Rosenberg, a petition (subject to Joint Rule 12) of Stanley C. Rosenberg and Ellen Story for legislation to allow municipal employment after retirement;

By the same Senator, a petition (subject to Joint Rule 12) of Stanley C. Rosenberg and Stephen Kulik for legislation to provide for a partial release of certain land in Whately from the operation of an agricultural preservation restriction; and

By the same Senator, a petition (subject to Joint Rule 12) of Stanley C. Rosenberg and Ellen Story for legislation to provide for a partial release of certain land in Amherst from the operation of an agricultural preservation restriction;
Severally, under Senate Rule 20, to the committees on Rules of the two branches, acting concurrently.

Reports of Committees.

By Mr. Tolman, for the committee on Mental Health and Substance Abuse, on petition, a Resolve relative to establishing a commission to set guidelines for development costs for housing for disabled adults (Senate, No. 1139);
Read and, under Joint Rule 29, referred to the committees on Rules of the two branches, acting concurrently.

By Ms. Tucker, for the committee on Elder Affairs, on petition, a Bill establishing a nursing facility conversion pilot program (Senate, No. 381);

By the same Senator, for the same committee, on petition, a Bill relative to nursing home audit disallowances (Senate, No. 373);

By the same Senator, for the same committee, on petition, a Bill relative to continuity of coverage for Medicaid beneficiaries over the age of 65 (Senate, No. 411);

By the same Senator, for the same committee, on petition, a Bill relative to reserving beds in nursing homes for residents during certain leaves of absence (Senate, No. 413);

By the same Senator, for the same committee, on petition, a Bill to create a nursing home advisory council (Senate, No. 1282); and

By Mr. Tolman, for the committee on Mental Health and Substance Abuse, on petition, a Bill authorizing educational psychologists to receive certain insurance payments (Senate, No. 1149);**Severally read and, under Joint Rule 1E, referred to the committee on Health Care Financing.**

By Mr. Barrios, for the committee on Public Safety and Homeland Security, on petition, a Bill prohibiting the use of paint ball guns (Senate, No. 1375);

By Mr. Tolman, for the committee on Mental Health and Substance Abuse, on petition (accompanied by bill, Senate, No. 1156), a Bill providing for the further treatment of substance abuse (Senate, No. 2268); and

By Ms. Jehlen, for the committee on Public Service, on Senate, No. 1129 and House, No. 315, a Bill relative to unionized public employees (Senate, No. 2269);
Severally read and, under Senate Rule 27, referred to the committee on Ways and Means.

Recess.

There being no objection, at eleven minutes past one o'clock P.M., the Chair (Ms. Walsh) declared a recess subject to the call of the Chair; and, at nineteen minutes before two o'clock P.M., the Senate reassembled, the President in the Chair.

The President, members, guests and employees then recited the pledge of allegiance to the flag.

The following prayer was offered by Father Bernard McLaughlin of St. Gerard's Parish in Canton:

God, you created us and the creation continues. You are our source and our destiny. Help us always to give strength to the weak and healing to the sick. Help us also to give love to the forlorn and lonely. Finally, help us to remember that we are all equal in your vision. Amen.

Resolutions.

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

Resolutions (filed by Mr. Tarr) "on the one hundred and seventy-fifth anniversary of the First Baptist Church of Rowley."

Orders of the Day.

The Orders of the Day were considered, as follows:

The House Bill promoting access to health care (House, No. 4479),— was read a second time.

The proposed amendment, previously recommended by the committee on Ways and Means, striking out all after the enacting clause and inserting in place thereof the text of Senate document numbered 2266; and by striking out the title and inserting in place thereof the following title: "An Act providing for health access, affordability and accountability.",— was considered.

Pending the question on adoption of the Ways and Means amendment, Ms. Chandler moved that the bill be amended in section 2A, line 15, by inserting, after the word "Executives," the following:— "1 of whom shall be a registered nurse nominated by the Massachusetts Nurses Association,".
The amendment was *rejected*.

Mr. Hart moved that the bill be amended by inserting, after section ___, the following new section:—

"SECTION XX. Chapter 176 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new chapter:—

CHAPTER 176Q.

Consumer Choice of Nurse Practitioner Services.

Section 1. As used in this chapter, the following words shall have the following meanings:

'Carrier', an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the Commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division

of medical assistance pursuant to chapter one hundred and eighteen E and in accordance with Title XIX of the Federal Social Security Act or any successor statute; and any other medical assistance program operated via a governmental unit for persons categorically eligible for such program.

‘Commissioner’, the commissioner of insurance.

‘Insured’, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

‘Non-discriminatory basis’, a carrier shall be deemed to be providing coverage on a non-discriminatory basis if said plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for diagnosis and treatment by other participating providers.

‘Nurse Practitioner’, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under the provisions of chapter 112, section 80B.

‘Participating Provider’, a provider who under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than co-insurance, co-payments or deductibles, directly or indirectly from the carrier.

‘Primary Care Provider’, a nurse practitioner or other health care professional qualified to provide general medical care for common health care problems. The provider supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care, within their scope of practice. Providers will often follow patients over long periods of time.

Section 2. The commissioner and the group insurance commission shall require that all carriers, on a nondiscriminatory basis, shall include coverage to their insured for care provided by nurse practitioners as participating providers for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include, but not be limited to, benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long term care setting, mental health or substance abuse programs, or other settings when rendered by a nurse practitioner practicing within the scope of her professional license.

Section 3. A nurse practitioner practicing within the scope of her licensure under the provisions of chapter 112, section 80B, shall be considered fully qualified as a primary care provider to an insured.

Section 4. Notwithstanding any special or General Law to the contrary, all carriers shall provide their insured with an opportunity to select a nurse practitioner as a primary care provider or to change their primary care provider to a nurse practitioner at any time during their coverage period.

Section 5. Notwithstanding any special or General Law to the contrary, all carriers shall ensure that all nurse practitioners in the carrier’s health plans are included on any publicly accessible list of participating providers for the carrier.

Section 6. Complaints of noncompliance against carriers shall be filed with and investigated by the commissioner or the group insurance commission whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce sections 2, 3, 4 and 5 above.”
The amendment was *rejected*.

Mr. Nuciforo moved that the bill be amended by striking out sections 32 and 33.
The amendment was *rejected*.

Mr. Havern moved that the bill be amended by adding, at the end thereof, the following new section:—

“Section 63. Protection against liability for physician apology to patient.

(1) For the purposes of any civil action against a person licensed by the Board of Registration in Medicine, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose and shall not be admissible in any civil action against such person.

(2) A person who is licensed by the Board of Registration in Medicine, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by said Board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

(3) Except as provided in subsection (2) of this section, this section applies to all expressions of regret or apology, whether made before, on or after the effective date of this Act. This section does not apply to any civil action in which a judgment was entered in the register of a court before the effective date of this Act. This section does not apply to any administrative proceeding in which a final order was entered before the effective date of this Act."
After remarks, the amendment was adopted.

Ms. Wilkerson, Mr. Barrios and Ms. Jehlen moved that the bill be amended in Chapter 28B(2) of section 4, by inserting, after the words "quality of health care services", the following:— "and that recognizes and makes adjustments for socioeconomic demographic data."; and in Chapter 28B(3) of section 4 by inserting, after the words "quality of health care services," the following:— "and that recognizes and makes adjustments for socioeconomic demographic data."
After remarks, the amendment was adopted.

Ms. Spilka moved that the bill be amended in section 33 by inserting, in subparagraph (c) of section 2A, after the text "within 30 calendar days of receipt of a completed application," the following words:— "or within 45 calendar days if the carrier provides its services on a national basis.".
The amendment was adopted.

Ms. Fargo and Mr. Timilty moved that the bill be amended in section 2A, by inserting, after the word "Executives,", in line 15, the following words:— "1 of whom shall be a registered nurse nominated by the Massachusetts nurses association".
The amendment was *rejected*.

Mr. Panagiotakos moved that the bill be amended by adding, at the end thereof, the following new sections:—

"SECTION ___. Section 35M of chapter 10 of the General Laws, as so appearing, is hereby amended by striking out, in lines 10 and 11, the following phrase:— 'and administration; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund.' and inserting in place thereof the following phrase:— ', administration and the statutory and regulatory responsibilities of the Board including patient protection, physician education and health care quality improvement.'."
After remarks, the amendment was adopted.

Mr. Barrios moved that the bill be amended in section 2 by adding the following item:—

"4512-0103 .....300,000".
The amendment was *rejected*.

Mr. Tisei moved that the bill be amended by inserting the following new section:—

"SECTION XX. Section 35M of chapter 10 of the General Laws, as so appearing, is hereby amended by striking out, in lines 10 and 11, the following phrase:— '; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund'.

The provisions of this section shall take effect on June 30, 2005."
The amendment was adopted.

Ms. Menard moved that the bill be amended by inserting, at the end thereof, the following new section:—

"SECTION ___. Chapter 111, section 1, as appearing in the 2004 Official Edition of the Massachusetts General Laws, is hereby amended by striking out the definitions of 'Health care provider' and inserting in place thereof the following new definition:—

'Health care provider', any doctor of medicine, osteopathy, or dental science, or a registered nurse, pharmacists, social worker, doctor of chiropractic, or psychologist licensed under the provisions of chapter one hundred and twelve, or an intern, or a resident, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, licensed pharmacy, or a hospital, clinic or nursing home licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees.

Chapter 111, section 1 is hereby further amended by inserting at the end of the definition of 'Medical peer review committee' or 'committee,' the following new language:—

'Medical peer review committee' shall also include a committee of a pharmacy society or association that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care; or a pharmacy peer review committee established by a person or entity that owns a licensed pharmacy or employs pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care.

Chapter 111, section 203 is hereby further amended by adding, at the end thereof, the following new subsection:—

(g) A licensed pharmacy may establish a pharmacy peer review committee to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care. The committee may review documentation of quality-related activities in a pharmacy, assess system failures and personnel deficiencies, determine facts, and make recommendations or issue decisions in a written report that can be used for contiguous quality improvement purposes. A pharmacy peer review committee includes the members, employees, and agents of the committee, including assistants, investigators, attorneys, and any other agents that serve the committee in any capacity.

Chapter 111, section 204 is hereby amended by inserting, after the word medicine, in lines 7 and 12, the word ‘pharmacy,’.

Chapter 111, section 204 is further amended in subsection (b) by adding after the word ‘medicine’, in line 28, the word ‘pharmacy,’.”
After remarks, the amendment was adopted.

Mr. Montigny moved that the bill be amended, S. 2266, by adding the following new section:—

“SECTION ___. Chapter 118E of the General Laws is hereby amended by inserting, after section 12, the following sections:—

Section 12A.

Consumer Protection Rules; Prior Authorization of Prescription Drugs.

(a) Any prior authorization process required by the division before it authorizes coverage for a prescription drug shall comply with the consumer protections in this section and with 42 U.S.C. section 1396r-8(d).

(b) Coverage for a prescription drug that is not covered by the division without prior authorization shall be authorized if a patient’s health care provider certifies, in a manner determined by the division, that:

(i) the drug is medically necessary; and

(ii) in the case of a prescription drug that is not the preferred choice in a therapeutic category on the preferred drug list,

(A) the preferred choice has not been effective, or with reasonable certainty is not expected to be effective in treating the patient’s condition; or

(B) the preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

(c) The prescriber’s certification concerning whether a particular drug has been ineffective, is expected to be ineffective in treating the patient, or is expected to cause an adverse or harmful reaction shall be final.

(d)(1) The division’s prior authorization process shall be designed to minimize administrative burdens on prescribers, pharmacists, and consumers.

(2) The prior authorization process shall ensure real-time receipt of requests, by telephone, voice mail, facsimile, electronic transmission, or mail on a 24-hour basis, seven days a week.

(3) The prior authorization process shall provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed 10 minutes.

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an emergency or urgent condition shall be responded to in no more than 4 hours from the time the program or participating health benefit plan receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the program or the participating health benefit plan, provided it is a prescription drug approved by the United States Food and Drug Administration, and provided, for drugs dispensed to a Medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

(6) The division shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least one form capable of being copied shall contain known patient information.

(e) The division’s prior authorization process shall require that the prescriber, not the pharmacy, request a prior authorization exception to the requirements of this section. The division may exempt a prescriber from the need to secure prior authorization

for a specific drug category if the division determines that the prescriber has written a minimum number of scripts in that category, and the prescriber prescribes prescription drugs on the preferred drug list at or above the minimum threshold for that category.

(f) If the patient is denied authorization of coverage, the denial shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A of the General Laws.

(g) The division shall, using bulletins, manuals, notices or other appropriate means, educate prescribers and pharmacists who treat MassHealth patients about the requirements of the prior authorization process, including the obligations of providers and pharmacists and the rights of consumers.

Section 12B.

Supplemental Rebates.

(a) The commissioner, separately or in concert with the authorized representatives of any health benefit plan participating in the prescription drug fair pricing program established by chapter 118H, shall use the division's preferred drug list of prescription drugs covered without a prior authorization requirement to negotiate with pharmaceutical companies for the payment to the commissioner of supplemental rebates or price discounts for Medicaid. The commissioner may also use the preferred drug list to negotiate for the payment of rebates or price discounts in connection with drugs covered under any other health benefit plan within or outside this state participating in the prescription drug fair pricing program established by chapter 118H. Such negotiations and any subsequent agreement shall comply with the provisions of 42 U.S.C. section 1396r-8. The program established by chapter 118H, or such portions of the program as the commissioner shall designate, shall constitute a state pharmaceutical assistance program under 42 U.S.C. Section 1396r-8(c)(1)(C). The provisions of this section do not authorize agreements with pharmaceutical manufacturers whereby financial support for medical services covered by the Medicaid program is accepted as consideration for placement of one or more prescription drugs on the preferred drug list or for excluding a drug from any prior authorization requirement.

(b) The commissioner shall provide quarterly reports on the progress of negotiating supplemental rebates pursuant to this section to the joint committee on health care and the house and senate committees on ways and means. By September 1, 2003, the commissioner shall provide with the next occurring quarterly report a cost-benefit analysis of alternative negotiation strategies, including strategies used by the state Medicaid agencies in states of Florida and Michigan to secure supplemental rebates and any other alternative negotiation strategy that might secure lower net prescription drug costs.

(c) The commissioner shall prohibit the public disclosure of information revealing company-identifiable trade secrets obtained by the department, and by any officer, employee or contractor of the department in the course of negotiations conducted pursuant to this section. Such confidential information shall be exempt from public disclosure.

Section 12C.

Discount Program Waiver.

(a) The division shall seek a prescription drug discount program waiver from the Centers for Medicare and Medicaid Services pursuant to section 1115(a) of the Social Security Act. The prescription drug discount program shall provide eligible individuals with a financial subsidy for prescription drugs equal to the average rebate paid to the Medicaid program by pharmaceutical manufacturers. Eligible individuals shall include Medicare-eligible individuals whose financial eligibility exceeds 188 per cent of federal poverty level and who do not have an insurance policy that covers drugs and other individuals whose financial eligibility does not exceed 300 per cent of the federal poverty level who do not have an insurance program that includes a prescription drug benefit.

(b) The division may establish, as part of the discount program, an annual enrollment fee. Subject to appropriation, the division shall make a payment of at least 2 percent of the cost of each prescription or refill dispensed to individuals enrolled in the program.

(c) In implementing the program, the division may contract with a nonprofit corporation or other entity to administer the program. Such corporation or entity shall agree to assist individuals enrolled in the program to access other free or discount prescription drug programs offered by private entities, including pharmaceutical manufacturers.

(d) The division shall report to the house and senate committees on ways and means and the joint committee on health care, not later than 60 days after the effective date of this section, on the division's progress in implementing this section and shall report every 90 days thereafter on its progress in obtaining the waiver to those committees.

SECTION 2. The General Laws are hereby amended by inserting the following new chapter:—

CHAPTER 118H.

The Massachusetts Prescription Drug Fair Pricing Program.

Section 1.

Program Established.

(a) There is hereby established a program to reduce the cost to the Commonwealth of providing prescription drugs to its citizens while maintaining high quality in prescription drug therapies. The program shall include, but shall not be limited to, the following components:

(1) the development and use of a statewide, uniform preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic and therapeutic equivalents;

(2) the creation of a single purchasing unit for the purchase of prescription drugs by the commonwealth;

(3) the use of strategies to negotiate with pharmaceutical manufacturers to lower the cost of prescription drugs for program participants, including a supplemental rebate program;

(4) the development of educational programs, including a counterdetailing program, designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to consumers, physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs;

(5) the utilization of any available cost containment tools that meet program objectives by reducing the cost to the commonwealth of obtaining and providing prescription drugs, including clinical management tools, utilization review procedures, a prior authorization review process, duplicate prescription monitoring, and refill and supply controls;

(6) the observance of consumer protection rules to maintain high quality in prescription drug therapies and to protect access to needed prescriptions; and

(7) the operation of a discount program to provide the benefit of negotiated price discounts to uninsured citizens.

(b) The following state agencies shall participate in the program authorized in this chapter, to the extent permitted by federal law:

(1) the division of medical assistance;

(2) the executive office of elder affairs;

(3) the group insurance commission;

(4) the department of public health;

(5) the department of mental health;

(6) the department of mental retardation;

(7) the department of corrections; and

(8) the division of employment and training.

(c) Any other public or private health benefit plan that purchases prescription drugs may elect to participate in all or portions of the program.

Section 2.

Bulk Purchasing Agreements.

(a) State agencies and other participants in the program shall act as a single purchasing unit for the negotiation of a contract to purchase prescription drugs on behalf of the commonwealth.

(b) The prescription drug procurement unit created by section 62 of chapter 177 of the Acts of 2001 shall implement all or part of the program to the extent permitted by federal law. The secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of the departments of public health, mental health and mental retardation

may renegotiate or amend existing contracts for the purchase of prescription drugs, including a contract made in conformance with said section 62, if such renegotiation or amendment is necessary to implement all or part of the program and will be of economic benefit to the health benefit plans subject to such contracts, and to the beneficiaries of such plans. Any renegotiated or substituted contract shall be designed to improve the overall quality of integrated health care services provided to beneficiaries of such plans.

Section 3.

Pharmaceutical Benefits Manager.

(a) State agencies and other participants in the program may contract with a third party pharmacy benefit manager to assist in implementation of the program. Such pharmacy benefit manager shall be a non-profit corporation with expertise in the management of pharmacy benefits.

(b) No contract shall be signed with a pharmacy benefit manager unless the pharmacy benefit manager has agreed to disclose to the commonwealth, in a manner that preserves the confidentiality of any proprietary information:

(1) operating statements of the pharmacy benefit manager;

(2) total revenue attributable to pharmaceutical manufacturer rebates and total revenue not attributable to pharmaceutical manufacturer rebates;

(3) all sources of rebate revenue and non-rebate revenue, and amounts of revenue from such sources;

(4) rebate management fees collected;

(5) the terms and conditions of any contract with any subcontractor, including contracts with the pharmacy benefit manager's pharmacy network; and

(6) the terms and conditions of any sale or exchange of prescription drug data concerning beneficiaries or the prescribing practices of the providers.

(c) No contract shall be signed with a pharmacy benefit manager that has entered into an agreement or engaged in one or more of the following practices unless a majority of state agency participants in the program determines, after consideration of all relevant circumstances, that such agreement or practice furthers the financial interests of the commonwealth, and does not adversely affect the financial or medical interests of beneficiaries:

(1) any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the pharmacy benefit manager and the manufacturer;

(2) any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the pharmacy benefit manager, or to pay soft money, so-called, or other economic benefits to the pharmacy benefit manager;

(3) any agreement to share revenue with a mail order or internet pharmacy company;

(4) any agreement or practice to bill the commonwealth's health benefit plans for prescription drugs at a cost higher than the pharmacy benefit manager pays the pharmacy; or

(5) any agreement to sell prescription drug data concerning beneficiaries, or data concerning the prescribing practices of health care providers.

Section 4.

Cost Containment Tools.

(a) The program shall include the following components:

(1) A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives.

(i) The preferred drug list shall be implemented as a uniform, statewide, preferred drug list for use by state agencies participating in the program and health benefit plans in the Commonwealth shall be encouraged to participate in the program.

(ii) The program may utilize the MassHealth Drug List developed by the division of medical assistance as its preferred drug list. In order to assist the state agencies participating in the program with the development, modification and timely revision of the preferred drug list, such agencies shall appoint a Drug List Review Board. The board may be comprised in whole or in part of representatives of state agencies, including the Drug Use Board established by the division of medical assistance pursuant to federal law, or may be established by contract with a public or private non-profit organization. The board shall:

(A) make recommendations for the adoption and maintenance of the preferred drug list based upon considerations of clinical efficacy, safety, and cost-effectiveness;

(B) meet at least quarterly;

(C) to the extent feasible, review all drug classes included in the preferred drug list at least every 12 months, and recommend additions to or deletions from the preferred drug list;.

(D) establish board procedures for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly approved prescription drugs in emergency circumstances, including early refill review standards, a prior authorization review process, duplicate prescription monitoring, and quality and supply controls;

(E) encourage health benefit plans to implement the preferred drug list as a uniform, statewide preferred drug list by inviting the representatives of each health benefit plan providing prescription drug coverage to residents of the commonwealth to participate as observers or nonvoting members in the commissioners drug utilization review board, and by inviting such plans to use the preferred drug list in connection with the plans' prescription drug coverage.

(iii) Members of the board shall receive per diem compensation and reimbursement of board related expenses. The board shall consult with a preferred drug list advisory group which shall include 1 designee of the commissioner of mental health; 1 designee of the commissioner of public health; 1 designee of the secretary of the executive office of elder affairs; 1 physician with experience treating MassHealth patients; 1 practicing pediatrician with experience treating MassHealth patients; 1 practicing pharmacist with experience serving MassHealth patients; 1 pharmacologist with expertise in psychiatric drugs; 1 representative of a senior citizens advocacy group; 1 representative of a disability advocacy group; and 1 representative of a statewide advocacy group representing the interests of MassHealth members.

(2) A series of educational programs including a counterdetailing program, designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs to consumers, physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs.

(3) Consideration of alternative pricing mechanisms including consideration of using maximum allowable cost pricing for generic and other prescription drugs.

(4) Consideration of alternative coverage terms, including consideration of providing coverage of over-the-counter drugs where cost-effective in comparison to prescription drugs, and authorizing coverage of dosages capable of permitting the consumer to split each pill if cost-effective and medically appropriate for the consumer.

(5) Development of a simple, uniform prescription form, designed to implement the preferred drug list, and to enable prescribers and consumers to request an exception to the preferred drug list choice with a minimum of cost and time to prescribers, pharmacists and consumers.

Section 5.

Consumer Protection Rules.

(a) The program shall authorize pharmacy benefit coverage when a patient's health care provider prescribes a prescription drug not on the preferred drug list, if a patient's health care provider certifies that:

(i) the drug is medically necessary; and

(ii) in the case of a prescription drug that is not the preferred choice in a therapeutic category on the preferred drug list,

(A) the preferred choice has not been effective, or with reasonable certainty is not expected to be effective in treating the patient's condition; or

(B) the preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

(b) The prescriber's certification concerning whether a particular drug has been ineffective, is expected to be ineffective in treating the patient, or is expected to cause an adverse or harmful reaction shall be final.

(c) The program shall authorize coverage notwithstanding any prior authorization requirement if the patient agrees to pay any additional cost in excess of the benefits provided by the patient's health benefit plan. The provisions of this paragraph shall not apply in circumstances in which their application is inconsistent with federal Medicaid laws and regulations. The provisions of this paragraph shall not affect implementation by a participating health benefit plan of tiered co-payments or other similar cost sharing systems.

(d) The program or any participating health benefit plan shall provide information on how prescribers, pharmacists, beneficiaries, and other interested parties can obtain a copy of the preferred drug list, whether any change has been made to the preferred drug list since it was last issued, and the process by which exceptions to the preferred list may be made.

(e)(1) The program's prior authorization process shall be designed to minimize administrative burdens on prescribers, pharmacists, and consumers.

(2) The prior authorization process shall ensure real-time receipt of requests, by telephone, voice mail, facsimile, electronic transmission, or mail on a 24-hour basis, seven days a week.

(3) The prior authorization process shall provide an in-person response to emergency requests by a prescriber with telephone answering queues that do not exceed 10 minutes.

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an emergency or urgent condition shall be responded to in no more than 4 hours from the time the program or participating health benefit plan receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the program or the participating health benefit plan, provided it is a prescription drug approved by the United States Food and Drug Administration, and provided, for drugs dispensed to a Medicaid beneficiary, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

(6) The program or participating plan shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least one form capable of being copied shall contain known patient information.

(f) The program's prior authorization process shall require that the prescriber, not the pharmacy, request a prior authorization exception to the requirements of this section. The program may exempt a prescriber from the need to secure prior authorization for a specific drug category if the program determines that the prescriber has written a minimum number of scripts in that category, and the prescriber prescribes prescription drugs on the preferred drug list at or above the minimum threshold for that category.

(g) If the patient is denied authorization of coverage, the denial shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A of the General Laws.

Section 6.

Discount Card Program.

(a) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall implement a pharmacy discount plan, to be known as the Healthy Massachusetts Discount Card Plan, for residents without adequate coverage for prescription drugs. As used in this section, a resident without adequate coverage means a resident of the commonwealth with no insurance coverage for prescription drugs or with coverage for which the annual maximum coverage limit under his health benefit plan has been reached. Such plan shall establish a system through which residents without adequate coverage are able to take advantage of discounted prices for prescription drugs negotiated pursuant to this chapter. Such commissioner shall implement the pharmacy discount program authorized by this section without any financial contribution by the state, and may establish an enrollment fee in such amount as is necessary to support the administrative costs of the plan. The plan shall be designed to work cooperatively with other state prescription drug assistance programs, including any program created pursuant to a discount program waiver granted by the Centers for Medicare and Medicaid Services to the division of medical assistance. Such commissioner may contract with a nonprofit corporation or other entity to administer the program. Such corporation or entity shall agree to assist individuals eligible for the program to access other free or discount prescription drug programs offered by private entities, including pharmaceutical manufacturers.

Section 7.

Reporting and Legislative Oversight.

(a) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall report quarterly to the joint committee on health care and the house and senate committees on ways and means on progress of the program in implementing a single state purchasing unit for prescription drugs pursuant to section 2. The report shall provide a status report on the formation of or operation of the contract negotiated pursuant to section 2, and shall identify any barriers to full implementation of section 2 and recommend any changes to the program or other legislative changes advisable to eliminate such barriers. The report shall also report on the program's progress in securing the participation of other health benefit plans with the commonwealth by means of joint purchasing agreements to enhance the commonwealth's purchasing power.

(b) Each year for the duration of the pharmacy benefit manager contract pursuant to section 3, the commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall provide a status report on the contract and the operations of the pharmacy benefit manager to the joint committee on health care and the house and senate committees on ways and means. The report shall include:

(1) a description of the activities of the pharmacy benefit manager;

(2) an analysis of the success of the pharmacy benefit manager in achieving each of the department's public policy goals, together with the pharmacy benefit manager's report of its activities and achievements;

(3) an assessment, based upon information learned in contracting with the pharmacy benefits manager, of administrative costs relating to prescription drug benefits in the Medicaid program and the Prescription Advantage program established pursuant to section 39 of chapter 19A, including any recommendations for increasing the administrative efficiency of such programs;

(4) any recommendations for enhancing the benefits of or minimizing inefficiencies of the pharmacy benefit manager contract or advancing the commonwealth's public policy goals relating to pharmaceutical costs, quality and access;

(5) a fiscal report on the costs and savings to the commonwealth of the pharmacy benefit manager contract, including the information disclosed pursuant to paragraph (b) of section 3, in a manner that preserves the confidentiality of any proprietary information; and

(6) if the pharmacy benefit manager engages in any of the activities described in paragraph (c) of section 3, an explanation of the reasons for finding that such agreement or practice furthers the financial interests of the commonwealth, and does not adversely affect the financial or medical interests of beneficiaries.

(c) The commissioner of health and human services or another commissioner of a participating state agency designated by program participants shall report quarterly to the joint committee on health care and the house and senate committees on ways and means concerning the cost containment aspects of the program undertaken pursuant to section 4. Such report shall include:

(1) a copy of the preferred drug list, an explanation of the list, a summary of the operation of the prior authorization process or any other cost savings measures instituted as a part of the list, and an estimate of expected cost savings as a result of the preferred drug list;

(2) a description of the efforts undertaken to educate consumers and health care providers about the preferred drug list and the program's utilization review procedures;

(3) a description of the efforts undertaken to establish programs to educate health care providers about the costs of prescribing patterns, including counter detailing programs;

(4) a report of other cost containment strategies undertaken, including, but not limited to, alternative pricing mechanisms and alternative coverage terms, the expected savings from such strategies, and the effect of such strategies on access to prescription drugs for consumers; and

(5) a status report on the development of a uniform prescription form and any barriers to such development.

(d) The joint committee on health care shall closely monitor implementation of the program, including the preferred drug list and utilization review procedures, to ensure that the consumer protection standards are not diminished as a result of implementing the preferred drug list and the utilization review procedures, including any unnecessary delay in access to appropriate medications. Such joint committee shall, by means of an oversight hearing or otherwise, ensure that all affected interests, including consumers, health care providers, pharmacists and others with pharmaceutical expertise have an opportunity to comment on the operation of the program, the preferred drug list, and other procedural aspects of the program.

SECTION 3. The General Laws are hereby amended by adding, after chapter 268B, the following chapter:—

CHAPTER 268C.

Physician and Pharmaceutical Manufacturer Conduct.

Section 1. As used in this chapter, the following words shall have the following meanings:—

‘Gift’, a payment, entertainment, subscription, advance, services or anything of value, unless consideration of equal or greater value is received. ‘Gift’ shall not include a commercially reasonable loan made in the ordinary course of business, anything of value received by inheritance, a gift received from a member of the reporting person’s immediate family or from a relative within the third degree of consanguinity of the reporting person or of the reporting person’s spouse or from the spouse of any such relative, or prescription drugs provided to a physician solely and exclusively for use by the physician’s patients.

‘Immediate family’, a spouse and any dependent children residing in the reporting person’s household.

‘Medical device’, an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:

(1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them,

(2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

(3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

‘Person’, a business, individual, corporation, union, association, firm, partnership, committee, or other organization or group of persons.

‘Pharmaceutical marketer’, a person who, while employed by or under contract to represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing, promotional activities, or other marketing of prescription drugs in this state to any physician, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to prescribe, dispense, or purchase prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A, a representative of such a distributor who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug, or a retail pharmacist registered under section 37 if such person is not engaging in such practices under contract with a manufacturing company.

‘Pharmaceutical manufacturing company’, any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A or a retail pharmacist registered under section 37.

‘Pharmaceutical manufacturer agent’, a pharmaceutical marketer or any other person who for compensation or reward does any act to promote, oppose or influence the prescribing of a particular prescription drug or medical device or category of prescription drugs or medical devices. The term shall not include a licensed pharmacist, licensed physician or any other licensed health care professional with authority to prescribe prescription drugs who is acting within the ordinary scope of the practice for which he is licensed.

‘Physician’, a person licensed to practice medicine by the board of medicine pursuant to section 2 of chapter 112.

‘Prescription drugs’, any and all drugs upon which the manufacturer or distributor has placed or must, in compliance with federal law and regulations, place the following or a comparable warning: ‘Caution federal law prohibits dispensing without prescription.’.

Section 2. No pharmaceutical manufacturer agent shall knowingly and willfully offer or give to a physician or a member of a physician’s immediate family, and no physician shall knowingly and willfully solicit or accept from any pharmaceutical manufacturer, gifts of any value at any time.

Section 3. A person who violates this section shall be punished by a fine of not more than $5,000 or by imprisonment for not more than 2 years, or both.

Section 4. The commissioner of the division of medical assistance, the secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of state agencies participating in the Massachusetts prescription drug fair pricing program established by chapter 118H of the General Laws shall take all steps necessary to enable the commonwealth to participate in joint prescription drug purchasing agreements with other states and other health benefit plans. Such steps shall include:

(1) Active collaboration with the National Legislative Association on Prescription Drug Prices in the Association's efforts;

(2) Active collaboration with the Pharmacy RFP Issuing States Initiative, so-called, organized by the West Virginia Public Employees Insurance Agency; and

(3) The execution of any joint purchasing agreements or other contracts with any health benefit plan or organization within or outside the state which such commissioners determines will lower the cost of prescription drugs for the commonwealth and its citizens while maintaining high quality in prescription drug therapies.

Section 5. (a) The General Court finds that the National Legislative Association on Prescription Drug Prices is a nonprofit organization of legislators formed for the purpose of making prescription drugs more affordable and accessible to citizens of the member states, including the commonwealth. The General Court further finds that the activities of the Association provide a public benefit to the people of the commonwealth.

(b) Three members of the senate, including one member of the minority party, shall be appointed directors of the Association by the senate president, and three members of the house of representatives, including one member of the minority party, shall be appointed directors of the Association by the speaker of the house. Directors so appointed shall serve until new members are appointed.

(c) The directors of the Association shall report to the house and senate committees on ways and means and the joint committees on health care and insurance on or before January 1 of each year with a summary of the activities of the Association, and any findings and recommendations for making prescription drugs more affordable and accessible to citizens of the commonwealth."
The amendment was adopted.

Ms. Chandler moved that the bill be amended in section 35, by inserting, after the words "University of Massachusetts Boston;" the following wording:— "a representative of the National Academy of Elder Law Attorneys Massachusetts Chapter;".
After remarks, the amendment was adopted.

Ms. Chandler moved that the bill be amended in section 35, by striking out the wording "provided further, that said commission shall also examine ways to provide incentives to people to purchase long term care insurance," and inserting in place thereof the following:— "provided further, that said commission shall also examine ways to market long term care insurance and provide incentives to people to purchase long term care insurance,"; and in said section by striking out the wording "December 31, 2005" and inserting in place thereof the following:— "December 31, 2006".
After remarks, the amendment was adopted.

Ms. Menard in the Chair, Mr. O'Leary moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Notwithstanding any general or special law to the contrary, health insurance suppliers may use no less than 80% of the revenue collected from premiums for providing care.".
The amendment was *rejected*.

Mr. Barrios moved that the bill be amended by striking out section 46.
The amendment was *rejected*.

Mr. Hart moved that the bill be amended by striking out section 46.
The amendment was *rejected*.

Ms. Jehlen and Mr. Hedlund moved that the bill be amended by striking out section 46.
The amendment was *rejected*.

Ms. Jehlen moved that the bill be amended by adding the following new section:—

"SECTION ___. Section 2 of chapter 32B of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by inserting, after the first sentence of subsection (d), in line 36, the following:— Persons who are ineligible because their duties

require less than twenty hours, regularly, during the regular work week may be provided health insurance pursuant to the provisions of a collective bargaining agreement.”.
The amendment was *rejected*.

Messrs. Morrissey, Timilty and Hedlund moved that the bill be amended by striking out section 46 in its entirety.
The amendment was *rejected*.

Mr. Brewer moved that the bill be amended in section 46 by striking out the word “employees” and inserting in place the following:— “full time employee”.
The amendment was *rejected*.

Ms. Spilka moved that the bill be amended in section 46 by striking out the words “Notwithstanding any general or special law or collective bargaining agreement to the contrary,”.
The amendment was *rejected*.

Ms. Walsh and Messrs. Tarr and Augustus moved that the bill be amended by inserting, after section ___, the following new sections:—

“SECTION ___. Section 3 of chapter 258B of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by inserting, after the word ‘court.’, in line 45, the first time it appears, the following sentence:— Before making a sentencing recommendation, the prosecutor shall provide the victim with a summary of the classification process conducted by the department of correction or the sheriff pursuant to sections 20, 20A or 21 of chapter 127 and the Code of Massachusetts Regulations on a form prepared by the department of correction. Such form shall also state that a copy of the defendant’s mittimus, tender of plea, if reduced to writing, and docket sheet, along with the telephone number of the correctional facility where the defendant will be initially incarcerated shall be made available by the victim-witness advocate to victims of crime, or family members thereof, for the crime committed by such defendant.

Said section 3 of said chapter 258B, as so appearing, is hereby further amended by adding the following clause:— (w) for victims and family members, to be provided with a copy of the defendant’s mittimus, tender of plea, if reduced to writing, and docket sheet along with the telephone number of the correctional facility where the defendant will be initially incarcerated by the victim-witness advocate.

‘SECTION ___. The provisions of sections ___ of this act amending chapter 258B of the General Laws shall be known as ‘Jason’s Law.’.”
The amendment was *rejected*.

Ms. Wilkerson and Mr. Barrios moved that the bill be amended in section 41 by adding, after the words “Shield of Massachusetts”, the following:— “and the Alliance of Massachusetts Safety Net Hospitals.”; and in section 42 by adding, after the words “Shield of Massachusetts”, the following:— “and the Alliance of Massachusetts Safety Net Hospitals.”.
After remarks, the amendment was adopted.

The President in the Chair, Ms. Fargo and Mr. Hedlund moved that the bill be amended by inserting, after section 62, the following new sections:—

“SECTION 63. (a) Section 70 of chapter 111 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by deleting the second and third sentence in the first paragraph in their entirety and inserting in place thereof the following two new sentences:— Such records may be made in handwriting, in print, by typewriting, in electronic digital media or conversion to electronic digital media as originally created by such hospital or clinic, by the photographic or microphotographic process, or any combination of the same. Such hospital or clinic, may only destroy said records after the applicable retention period has elapsed upon notifying the department of public health that the applicable retention period has elapsed and the records will be destroyed. Such Hospital or Clinic shall further provide information through applicable provisions contained in the hospital or clinic notice of privacy practices or through mailing a notice to the patient’s last known address that records will be terminated after the applicable retention period has elapsed since the last date of service.

(b) Section 70 of chapter 111 of the General Laws, as so appearing, is hereby amended by deleting the word ‘thirty’ in the last sentence of the first paragraph and inserting in place thereof the word ‘fifteen’.

(c) Section 36 of Chapter 123 of the General Laws, as so appearing, is hereby amended by adding, at the end thereof, the following new sentences:— Each facility, subject to provisions of this chapter and Section 19 of Chapter 19 who provide mental health care and treatment shall maintain records of individual patients’ records are so defined under section 70 of chapter 111, for at least fifteen years after closing of the record due to discharge, death, or last contact. Such facility may destroy said records after the applicable retention period has elapsed upon notifying the department that the applicable retention period has elapsed and the records will be destroyed. Said facility shall further provide information through applicable provisions in the hospital or

clinic notice of privacy practices or through mailing a notice to the patient's last known address that records will be terminated after the applicable retention period has elapsed since the last date of service.

(d) The Department of Public Health and the Department of Mental Health shall consult with the Massachusetts Hospital Association, the Massachusetts Medical Society, and the Massachusetts Association of Behavioral Health Systems prior to developing regulations required under this Act. Promulgation or amendment of said regulations shall occur within 120 days of the effective date of this Act."
The amendment was *rejected*.

Mr. Rosenberg moved that the bill be amended by inserting, after section ___, the following new section:—

'SECTION ___.

Section 1.

Preamble.

Whereas, The health of the people of Massachusetts is the foundation for the welfare of the Commonwealth; and

Whereas, It is in the public interest to guarantee every resident timely access to health care, to assure high quality of health services, to assure adequate and stable financing for all providers of health care, and to apportion the costs of care in the most equitable manner possible; and

Whereas, At least half a million Massachusetts residents have no health insurance at all and millions more residents have insurance which is inadequate for their needs; and

Whereas, Massachusetts spends significantly more per capita on health care than any other state or nation, putting our state and our businesses at a competitive disadvantage to other states and to all the foreign countries where governments provide universal health care; and

Whereas, Unstable and unaffordable rate increases for health insurance is causing significant economic hardship for Massachusetts residents and their employers; and

Whereas, The annual double digit increases in the cost of private health insurance are leading more Massachusetts employers to shift costs onto workers or drop insurance of employees and retirees altogether; and

Whereas, The escalating cost of insuring public employees is increasing taxpayer burden and preventing municipalities, and the Commonwealth itself, from investing in education, public works, human services, environmental protections, and other projects needed for the public good; and

Whereas, The skyrocketing cost of prescription drugs is depriving our people of medications which save lives and prevent costly illness; and

Whereas, Needed community hospitals, nursing homes, and home health agencies of the state have closed due to inadequate reimbursement of costs; and

Whereas, Efforts to control health care costs while maintaining the private health insurance market invariably lead to diminished access and quality in health care; and

Whereas, Up to forty percent of every Massachusetts health care dollar goes to inefficient, redundant administrative systems; and

Whereas, Independent quantitative analyses have shown that, under a single payer public health insurance system, Massachusetts could afford to cover all residents at no new cost to the state; and

Whereas, The same studies have shown that by simplifying administration, achieving bulk purchase discounts on pharmaceuticals and medical supplies, and reducing the use of emergency facilities for primary care, Massachusetts could divert billions of dollars toward providing direct health care and improved quality and access; and

Whereas, Unacceptable health access disparities exist by region, ethnicity, income, and gender; and

Whereas, Advances in medical technology are not available to all Massachusetts residents who need them; and

Whereas, Both health care providers and consumers express significant dissatisfaction with the current health care system; and

Whereas, Increasing patient volume and a decline in the number of hospitals and emergency departments have made multiple hour waits for emergency care the norm and that ambulance diversion is becoming a common method of dealing with emergency department overcrowding, a problem that poses significant dangers for both insured and uninsured residents of the Commonwealth;

Therefore, The Massachusetts Health Care Trust, a single agency of the Commonwealth, is hereby created with the following purposes:

(a) To provide universal and affordable health care coverage for all Massachusetts residents;

(b) To provide Massachusetts residents with an extensive benefit package;

(c) To control health care costs and the growth of health care spending;

(d) To achieve measurable improvement in health care outcomes;

(e) To prevent disease and disability and to maintain or improve health and functionality;

(f) To increase health care provider, consumer, employee, and employer satisfaction with the health care system;

(g) To implement policies to strengthen and improve culturally and linguistically sensitive care; and

(h) To develop an integrated population-based health care database to support health care planning.

Section 2.

Definitions.

The following words and phrases as used in this chapter shall have the following meanings, except where the context clearly requires otherwise:—

‘Board’ means the board of trustees of the Massachusetts Health Care Trust.

‘Employer’ means every person, partnership, association, corporation, trustee, receiver, the legal representatives of a deceased employer and every other person, including any person or corporation operating a railroad and any public service corporation, the state, county, municipal corporation, township, school or road, school board, board of education, curators, managers or control commission, board or any other political subdivision, corporation, or quasi-corporation, or city or town under special charter, or under the commission for of government, using the service of another for pay in the commonwealth.

‘Executive Director’ means the executive director of the Massachusetts Health Care Trust.

‘Health care’ means care provided to a specific individual by a licensed health care professional to promote physical and mental health, to treat illness and injury and to prevent illness and injury.

‘Health care facility’ means any facility or institution, whether public or private, proprietary or nonprofit, that is organized, maintained, and operated for health maintenance or for the prevention, diagnosis, care and treatment of human illness, physical or mental, for one or more persons.

‘Health care provider’ means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by law to provide professional health care services to an individual in the commonwealth.

‘Health maintenance organization’ means a provider organization that meets the following criteria:

(1) Is fully integrated operationally and clinically to provide a broad range of health care services;

(2) Is compensated using capitation or overall operating budget; and

(3) Provides health care services primarily through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

‘Professional advisory committee’ means a committee of advisors appointed by a director of a division of the Massachusetts Health Care Trust.

‘Resident’ means a person who lives in Massachusetts as evidenced by an intent to continue to live in Massachusetts and to return to Massachusetts if temporarily absent, coupled with an act or acts consistent with that intent. The Trust shall adopt standards and procedures for determining whether a person is a resident. Such rules shall include:

(1) a provision requiring that the person seeking resident status has the burden of proof in such determination;

(2) a provision requiring reasonable durational domicile requirements not to exceed 2 years for long term care and 90 days for all other covered services;

(3) a provision that a residence established for the purpose of seeking health care shall not by itself establish that a person is a resident of the commonwealth; and

(4) a provision that, for the purposes of this chapter, the terms ‘domicile’ and ‘dwelling place’ are not limited to any particular structure or interest in real property and specifically includes homeless individuals with the intent to live and return to Massachusetts if temporarily absent coupled with an act or acts consistent with that intent.

‘Secretary’ means the secretary of the executive office of health and human services.

‘Trust’ means the Massachusetts Health Care Trust established in section five of this chapter.

‘Trust Fund’ means the Massachusetts Health Care Trust Fund established in section nineteen of this chapter.

Section 3.

Establishment of Massachusetts Health Care Trust.

There is hereby created an independent body, politic and corporate, to be known as the Massachusetts Health Care Trust, hereinafter referred to as the Trust, to function as the single public agency, or ‘single payer’, responsible for the collection and disbursement of funds required to provide health care services for every resident of the Commonwealth. The Trust is hereby constituted a public instrumentality of the commonwealth and the exercise by the Trust of the powers conferred by this chapter shall be deemed and held the performance of an essential governmental function. The Trust is hereby placed in the executive office of the health and human services but shall not be subject to the supervision or control of said office or of any board, bureau, department or other agency of the commonwealth except as specifically provided by this chapter.

The provisions of chapter two hundred sixty-eight A shall apply to all trustees, officers and employees of the Trust, except that the Trust may purchase from, contract with or otherwise deal with any organization in which any trustee is interested or involved; provided, however, that such interest or involvement is disclosed in advance to the trustees and recorded in the minutes of the proceedings of the Trust; and provided, further, that a trustee having such interest or involvement may not participate in any decision relating to such organization.

Neither the Trust nor any of its officers, trustees, employees, consultants or advisors shall be subject to the provisions of section three B of chapter seven, sections nine A, forty-five, forty-six and fifty-two of chapter thirty, chapter thirty B or chapter thirty-one; provided, however, that in purchasing goods and services, the corporation shall at all times follow generally accepted good business practices.

All officers and employees of the Trust having access to its cash or negotiable securities shall give bond to the Trust at its expense, in such amount and with such surety as the board of trustees shall prescribe. The persons required to give bond may be included in one or more blanket or scheduled bonds.

Trustees, officers and advisors who are not regular, compensated employees of the Trust shall not be liable to the commonwealth, to the Trust or to any other person as a result of their activities, whether ministerial or discretionary, as such trustees, officers or advisors except for willful dishonesty or intentional violations of law. The board of the Trust may purchase liability insurance for trustees, officers, advisors and employees and may indemnify said persons against the claims of others.

Section 4.

Powers.

The Trust shall have the following powers:

(1) to make, amend and repeal by-laws, rules and regulations for the management of its affairs;

(2) to adopt an official seal;

(3) to sue and be sued in its own name;

(4) to make contracts and execute all instruments necessary or convenient for the carrying on of the purposes of this chapter;

(5) to acquire, own, hold, dispose of and encumber personal, real or intellectual property of any nature or any interest therein;

(6) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity;

(7) to appear on its own behalf before boards, commissions, departments or other agencies of federal, state or municipal government;

(8) to appoint officers and to engage and employ employees, including legal counsel, consultants, agents and advisors and prescribe their duties and fix their compensation;

(9) to establish advisory boards;

(10) to procure insurance against any losses in connection with its property in such amounts, and from such insurers, as may be necessary or desirable;

(11) to invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, in such investments as may be lawful for fiduciaries in the commonwealth pursuant to sections thirty-eight and thirty-eight A of chapter twenty-nine;

(12) to accept, hold, use, apply, and dispose of any and all donations, grants, bequests and devises, conditional or otherwise, of money, property, services or other things of value which may be received from the United States or any agency thereof, any governmental agency, any institution, person, firm or corporation, public or private, such donations, grants, bequests and devises to be held, used, applied or disposed for any or all of the purposes specified in this chapter and in accordance with the terms and conditions of any such grant. Receipt of each such donation or grant shall be detailed in the annual report of the Trust; such annual report shall include the identity of the donor, lender, the nature of the transaction and any conditions attaching thereto;

(13) to do any and all other things necessary and convenient to carry out the purposes of this chapter.

Section 5.

Purposes.

The purposes of the Massachusetts Health Care Trust shall include the following:

(1) To guarantee every Massachusetts resident access to high quality health care by:

(a) providing reimbursement for all medically appropriate health care services offered by the eligible provider or facility of each resident’s choice;

(b) funding capital investments for adequate health care facilities and resources statewide

(2) To save money by replacing the current mixture of public and private health care plans with a uniform and comprehensive health care plan available to every Massachusetts resident;

(3) To replace the redundant private and public bureaucracies required to support the current system with a single administrative and payment mechanism for covered health care services;

(4) To use administrative and other savings to:

(a) expand covered health care services;

(b) contain health care cost increases; and

(c) create provider incentives to innovate and compete by improving health care service quality and delivery to patients;

(5) To fund, approve and coordinate capital improvements in excess of a threshold to be determined annually by the executive director to qualified health care facilities to:

(a) avoid unnecessary duplication of health care facilities and resources; and

(b) encourage expansion or location of health care providers and health care facilities in underserved communities;

(6) To assure the continued excellence of professional training and research at Massachusetts health care facilities;

(7) To achieve measurable improvement in health care outcomes;

(8) To prevent disease and disability and maintain or improve health and functionality;

(9) To ensure that all Massachusetts residents receive care appropriate to their special needs as well as care which is culturally and linguistically sensitive;

(10) To increase satisfaction with the health care system among health care providers, consumers, and the employers and employees of the commonwealth;

(11) To implement policies which strengthen and improve culturally and linguistically sensitive care;

(12) To develop an integrated population-based health care database to support health care planning; and

(13) To fund training and re-training programs for professional and non-professional workers in the health care sector displaced as a direct result of implementation of this chapter.

Section 6.

Board of trustees; composition; powers and duties.

The Trust shall be governed by a board of trustees with twenty-three members. The board shall include the secretary of health and human services, the secretary of administration and finance and the commissioner of public health. The governor shall appoint an additional twelve trustees from a pool of candidates nominated by organizations as described herein: two appointed trustees shall be nominated by statewide organizations who have a record of advocating for universal single payer health care in Massachusetts; one appointed trustee shall be nominated by an organization representing Massachusetts senior citizens; one appointed trustee shall be nominated by an organization representing a statewide organization defending the rights of children; one appointed trustee shall be nominated by an organization providing legal services to low income clients; one appointed trustee shall be nominated by a statewide labor organization; three appointed trustees shall be nominated by statewide organizations of health care professionals who deliver direct patient care; one appointed trustee shall be nominated by a statewide organization of health care facilities; one appointed trustee shall be nominated by an organization representing non-healthcare employers; and one appointed trustee shall be a health care economist.

In addition, eight trustees, who are eligible to receive the benefits of the Massachusetts Health Care Trust but who do not fall into any of the aforementioned categories, shall be elected by the citizens of the Commonwealth, one from each of the Governor's Council districts. Elected trustees shall be elected for four-year terms, and each shall be eligible for re-election once.

Each appointed trustee shall serve a term of five years; provided, however, that initially four appointed trustees shall serve three year terms, four appointed trustees shall serve four year terms, and four appointed trustees shall serve five year terms. The initial appointed trustees shall be assigned to a three, four, or five year term by lot. Any person appointed to fill a vacancy on the board shall serve for the unexpired term of the predecessor trustee. Any appointed trustee shall be eligible for reappointment. Any appointed trustee may be removed from his appointment by the governor for just cause. The board shall elect a chair from among its members every two years. Ten trustees shall constitute a quorum and the affirmative vote of a majority of the trustees present and eligible to vote at a meeting shall be necessary for any action to be taken by the board. The board of trustees shall meet at least ten times each year and will have final authority over the activities of the Trust.

The trustees shall be reimbursed for actual and necessary expenses and loss of income incurred for each full day serving in the performance of their duties to the extent that reimbursement of those expenses is not otherwise provided or payable by another public agency or agencies. For purposes of this section, 'full day of attending a meeting' shall mean presence at, and participation in, not less than 75 percent of the total meeting time of the board during any particular 24-hour period.

No member of the board of trustees shall make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she, or a family member or a business partner or colleague has a financial interest.

In general, the board is responsible for ensuring universal access to high quality, affordable health care for every resident of the Commonwealth. The Board shall specifically address all of the following:

(1) Establish policy on medical issues, population-based public health issues, research priorities, scope of services, expanding access to care, and evaluation of the performance of the system;

(2) Evaluate proposals from the executive director and others for innovative approaches to health promotion, disease and injury prevention, health education and research, and health care delivery.

(3) Establish standards and criteria by which requests by health facilities for capital improvements shall be evaluated.

Section 7.

Executive director; purpose and duties.

The board of trustees shall hire an executive director who shall be the executive and administrative head of the Trust and shall be responsible for administering and enforcing the provisions of law relative to the Trust.

The executive director may, as s/he deems necessary or suitable for the effective administration and proper performance of the duties of the Trust and subject to the approval of the board of trustees, do the following:

(1) adopt, amend, alter, repeal and enforce, all such reasonable rules, regulations and orders as may be necessary;

(2) appoint and remove employees and consultants; provided, however, that, subject to the availability of funds in the Trust, at least one employee shall be hired to serve as director of each of the divisions created in sections eight through twelve, inclusive, of this chapter.

The executive director shall:

(1) establish an enrollment system that will ensure that all eligible Massachusetts residents are formally enrolled;

(2) utilize the purchasing power of the state to negotiate price discounts for prescription drugs and all needed durable and nondurable medical equipment and supplies;

(3) negotiate or establish terms and conditions for the provision of high quality health care services and rates of reimbursement for such services on behalf of the residents of the commonwealth;

(4) develop prospective and retrospective payment systems for covered services to provide prompt and fair payment to eligible providers and facilities;

(5) oversee preparation of annual operating and capital budgets for the statewide delivery of health care services;

(6) oversee preparation of annual benefits reviews to determine the adequacy of covered services; and

(7) prepare an annual report to be submitted to the governor, the president of the senate and speaker of the house of representatives and to be easily accessible to every Massachusetts resident.

The executive director of the trust may utilize and shall coordinate with the offices, staff and resources of any agencies of the executive branch including, but not limited to, the executive office of health and human services and all line agencies under its jurisdiction, the division of health care finance and policy, the department of revenue, the insurance division, the group insurance commission, the department of employment and training, the industrial accidents board, the health and educational finance authority, and all other executive agencies.

Section 8.

Regional division; director, offices, purposes and duties.

There shall be a regional division within the Trust which shall be under the supervision and control of a director. The powers and duties given the director in this chapter and in any other general or special law shall be exercised and discharged subject to the control and supervision of the executive director of the Trust. The director of the regional division shall be appointed by the executive director of the Trust, with the approval of the board of trustees, and may, with like approval, be removed. The director may, at his/her discretion, establish a professional advisory committee to provide expert advice; provided, however, that such committee shall have at least 25% consumer representation.

The Trust shall have a reasonable number of regional offices located throughout the state. The number and location of these offices shall be proposed to the executive director and board of trustees by the director of the regional division after consultation with the directors of the planning, administration, quality assurance and information technology divisions and consideration of convenience and equity. The adequacy and appropriateness of the number and location of regional offices shall be reviewed by the board at least once every three years.

Each regional office shall be professionally staffed to perform local outreach and informational functions and to respond to questions, complaints, and suggestions from health care consumers and providers. Each regional office shall hold hearings annually to determine unmet health care needs and for other relevant reasons. Regional office staff shall immediately refer evidence of unmet needs or of poor quality care to the director of the regional division who will plan and implement remedies in consultation with the directors of the administrative, planning, quality assurance, and information technology divisions.

Section 9.

Administrative division; director; purpose and duties.

There shall be an administrative division within the Trust which shall be under the supervision and control of a director. The powers and duties given the director in this chapter and in any other general or special law shall be exercised and discharged subject to the direction, control and supervision of the executive director of the Trust. The director of the administrative division shall be appointed by the executive director of the Trust, with the approval of the board of trustees, and may, with like approval, be removed. The director may, at his/her discretion, establish a professional advisory committee to provide expert advice; provided, however, that such committee shall have at least 25% consumer representation.

The administrative division shall have day-to-day responsibility for:

(1) making prompt payments to providers and facilities for covered services;

(2) collecting reimbursement from private and public third party payers and individuals for services not covered by this chapter or covered services rendered to non-eligible patients;

(3) developing information management systems needed for provider payment, rebate collection and utilization review;

(4) investing trust fund assets consistent with state law and section nineteen of this chapter;

(5) developing operational budgets for the Trust; and

(6) assisting the planning division to develop capital budgets for the Trust.

Section 10.

Planning division; director; purpose and duties.

There shall be a planning division within the Trust which shall be under the supervision and control of a director. The powers and duties given the director in this chapter and in any other general or special law shall be exercised and discharged subject to the direction, control and supervision of the executive director of the Trust. The director of the planning division shall be appointed by the executive director of the Trust, with the approval of the board of trustees, and may, with like approval, be removed. The director may, at his/her discretion, establish a professional advisory committee to provide expert advice; provided, however, that such committee shall have at least 25% consumer representation.

The planning division shall have responsibility for coordinating health care resources and capital expenditures to ensure all eligible participants reasonable access to covered services. The responsibilities shall include but are not limited to:

(1) An annual review of the adequacy of health care resources throughout the commonwealth and recommendations for changes. Specific areas to be evaluated include but are not limited to the resources needed for underserved populations and geographic areas, for culturally and linguistically competent care, and for emergency and trauma care. The director will develop short-term and long-term plans to meet health care needs.

(2) An annual review of capital health care needs. Included in this evaluation, but not limited to it are recommendations for a budget for all health care facilities, evaluating all capital expenses in excess of a threshold amount to be determined annually by the executive director, and collaborating with local and statewide government and health care institutions to coordinate capital health planning and investment. The director will develop short-term and long-term plans to meet capital expenditure needs.

In making its review, the planning division shall consult with the regional offices of the Trust and shall hold hearings throughout the state on proposed recommendations. The division shall submit to the board of trustees its final review and recommendations by October 1 of each year. Subject to board approval, the Trust shall adopt the recommendations.

Section 11.

Information technology division; purpose and duties.

There shall be an information technology division within the Trust which shall be under the supervision and control of a director. The powers and duties given the director in this chapter and in any other general or special law shall be exercised and discharged subject to the direction, control and supervision of the executive director of the Trust. The director of the information technology division shall be appointed by the executive director of the Trust, with the approval of the board of trustees, and may, with like approval, be removed. The director may, at his/her discretion, establish a professional advisory committee to provide expert advice; provided, however, that such committee shall have at least 25% consumer representation.

The responsibilities of the information technology division shall include but are not limited to:

(1) developing a confidential electronic medical records system and prescription system in accordance with laws and regulations to maintain accurate patient records and to simplify the billing process, thereby reducing medical errors and bureaucracy;

(2) developing a tracking system to monitor quality of care, establish a patient data base and promote preventive care guidelines and medical alerts to avoid errors.

Notwithstanding that all billing shall be performed electronically, patients shall have the option of keeping any portion of their medical records separate from their electronic medical record.

The information technology director shall work closely with the directors of the regional, administrative, planning and quality assurance divisions. The information technology division shall make an annual report to the board of trustees by October 1 of each year. Subject to board approval, the Trust shall adopt the recommendations.

Section 12.

Quality assurance division; director; purpose and duties.

There shall be a quality assurance division within the Trust which shall be under the supervision and control of a director. The powers and duties given the director in this chapter and in any other general or special law shall be exercised and discharged subject to the direction, control and supervision of the executive director of the Trust. The director of the quality assurance division shall be appointed by the executive director of the Trust, with the approval of the board of trustees, and may, with like approval, be removed. The director may, at his/her discretion, establish a professional advisory committee to provide expert advice; provided, however, that such committee shall have at least 25% consumer representation.

The quality assurance division shall support the establishment of a universal, best quality of standard of care with respect to:

(a) appropriate staffing levels;

(b) appropriate medical technology;

(c) design and scope of work in the health workplace; and

(d) evidence-based best clinical practices.

The director shall conduct a comprehensive annual review of the quality of health care services and outcomes throughout the commonwealth and submit such recommendations to the board of trustees as may be required to maintain and improve the quality of health care service delivery and the overall health of Massachusetts residents. In making its reviews, the quality assurance division shall consult with the regional, administrative, and planning divisions and hold hearings throughout the state on quality of care issues. The division shall submit to the board of trustees its final review and recommendations on how to ensure the highest quality health care service delivery by October 1 of each year. Subject to board approval, the Trust shall adopt the recommendations.

Section 13.

Eligible participants.

Those persons who shall be recognized as eligible participants in the Massachusetts Health Care Trust shall include:

(1) all Massachusetts residents;

(2) all non-residents who:

(a) work 20 hours or more per week in Massachusetts ;

(b) pay all applicable Massachusetts personal income and payroll taxes;

(c) pay any additional premiums established by the Trust; and

(d) have complied with requirements (a) through (c) inclusive for at least 90 days.

(3) All non-resident patients requiring emergency treatment for illness or injury; provided, however, that the trust shall recoup expenses for such patients wherever possible.

Payment for emergency care of Massachusetts residents obtained out of state shall be at prevailing local rates. Payment for non-emergency care of Massachusetts residents obtained out of state shall be according to rates and conditions established by the executive director. The executive director may require that a resident be transported back to Massachusetts when prolonged treatment of an emergency condition is necessary.

Visitors to Massachusetts shall be billed for all services received under the system. The executive director of the Trust may establish intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors.

Section 14.

Eligible health care providers and facilities.

Eligible health care providers and facilities shall include an agency, facility, corporation, individual, or other entity directly rendering any covered benefit to an eligible patient: provided, however, that the provider or facility:

(1) is licensed to operate or practice in the commonwealth;

(2) earns no more than 5% of its income by providing health care services covered by, but not paid for, by the trust: provided, however, that when such services are provided at an otherwise eligible health care facility, the provider must reimburse the Trust for an amount to be determined by the Trust but not less than the value of the fully loaded overhead cost of the provider's use of the facility plus the provider's share of the value of any public subsidies to the facility;

(3) furnishes a signed agreement that:

(a) all health care services will be provided without discrimination on the basis of age, sex, race, national origin, sexual orientation, income status or preexisting condition;

(b) the provider or facility will comply with all state and federal laws regarding the confidentiality of patient records and information;

(c) no balance billing or out-of-pocket charges will be made for covered services unless otherwise provided in this chapter; and

(d) the provider or facility will furnish such information as may be reasonably required by the Trust for making payment, verifying reimbursement and rebate information, utilization review analyses, statistical and fiscal studies of operations and compliance with state and federal law;

(4) meets state and federal quality guidelines including guidance for safe staffing, quality of care, and efficient use of funds for direct patient care;

(5) is a public or non-profit institution that is not investor-owned;

(6) is a non-profit health maintenance organization that actually delivers care in its facilities and employs clinicians on a salaried basis; and

(7) meets whatever additional requirements that may be established by the Trust.

Section 15.

Prospective payments to eligible health care providers and facilities for operating expenses.

The Trust shall negotiate, with eligible health care providers, health care facilities or groups of providers or facilities, payment rates for covered services. Such payment rates may be made on a fee for service, capitated system or overall operating budget basis and shall remain in effect for a period of 12 months unless sooner modified by the Trust. Except as provided in section sixteen of this chapter, reimbursement for covered services by the Trust shall constitute full payment for the services rendered.

Payment provided under this section can be used only to pay for the operating costs of eligible health care providers or facilities, including reasonable expenditures, as determined through budget negotiations with the Trust, for the maintenance, replacement and purchase of equipment. Payments for operating expenses shall not be used to finance capital expenditures; payment of

exorbitant salaries; or for activities to assist, promote, deter or discourage union organizing. Any prospective payments made in excess of actual costs for covered services shall be returned to the Trust. Prospective payment rates and schedules shall be adjusted annually to incorporate retrospective adjustments.

Section 16.

Retrospective payments to eligible health care providers and facilities for operating expenses.

The Trust shall provide for retrospective adjustment of payments to eligible health care facilities and providers to:

(1) assure that payments to such providers and facilities reflect the difference between actual and projected utilization and expenditures for covered services; and

(2) protect health care providers and facilities who serve a disproportionate share of eligible participants whose expected utilization of covered health care services and expected health care expenditures for such services are greater than the average utilization and expenditure rates for eligible participants statewide.

Payments provided under this section can be used only to pay for the operating costs of eligible health care providers and facilities, including reasonable expenditures, as determined through budget negotiations with the Trust, for the maintenance, replacement and purchase of equipment. Payments for operating costs shall not be used to finance capital expenditures; for the payment of exorbitant salaries; or for activities to assist, promote, deter or discourage union organizing.

Section 17.

Prospective funding for capital investments by eligible health care providers and facilities.

The Trust, through its planning division, shall negotiate with eligible health care providers, health care facilities, or groups of providers or facilities, capital budgets to ensure adequate access to high quality health care for all Massachusetts residents. The Trust shall provide funding for payment of debt service on outstanding bonds as of the effective date of this Act and shall be the sole source of future funding, whether directly or indirectly, through the payment of debt service, for capital expenditures by health care providers and facilities covered by the Trust in excess of a threshold amount to be determined annually by the executive director.

Section 18.

Benefits.

The Trust shall pay for all professional services provided by eligible providers and facilities to eligible participants needed to:

(1) provide high quality, appropriate and medically necessary health care services;

(2) encourage reductions in health risks and increase use of preventive and primary care services; and

(3) integrate physical health, mental and behavioral health and substance abuse services.

Covered services shall include all health care determined to be medically necessary or appropriate by the Trust, including, but not limited to, the following:

(1) prevention, diagnosis and treatment of illness and injury, including laboratory, diagnostic imaging, inpatient, ambulatory and emergency medical care, blood and blood products, dialysis, mental health services, dental care, acupuncture, physical therapy, chiropractic and podiatric services;

(2) promotion and maintenance of individual health through appropriate screening, counseling and health education;

(3) the rehabilitation of sick and disabled persons, including physical, psychological, and other specialized therapies;

(4) prenatal, perinatal and maternity care, family planning, fertility and reproductive health care;

(5) home health care including personal care;

(6) long term care in institutional and community-based settings;

(7) hospice care;

(8) language interpretation and such other medical or remedial services as the Trust shall determine;

(9) emergency and other medically necessary transportation;

(10) the full scale of dental services, other than cosmetic dentistry;

(11) basic vision care and correction, other than laser vision correction for cosmetic purposes;

(12) hearing evaluation and treatment including hearing aids;

(13) prescription drugs; and

(14) durable and non-durable medical equipment, supplies and appliances.

No deductibles, co-payments, co-insurance, or other cost sharing shall be imposed with respect to covered benefits.

Patients shall have free choice of participating physicians and other clinicians, hospitals, inpatient care facilities and other providers and facilities.

Section 19.

Establishment health care trust fund.

In order to support the Trust effectively, there is hereby established the health care trust fund, hereinafter the Trust Fund, which shall be administered and expended by the executive director of the Trust subject to the approval of the board. The Fund shall consist of all revenue sources defined in section twenty-one, and, all property and securities acquired by and through the use of monies deposited to the Trust Fund and all interest thereon less payments therefrom to meet liabilities incurred by the Trust in the exercise of its powers and the performance of its duties under this chapter.

All claims for health care services rendered shall be made to the Trust Fund and all payments made for health care services shall be disbursed from the Trust Fund. The executive director shall from time to time requisition for said Trust Fund such amounts as the executive director deems necessary to meet the Trust's current obligations for a reasonable future period.

Section 20.

Purpose of the Trust Fund.

Amounts credited to the Trust Fund shall be used for the following purposes:

(1) to pay eligible health care providers and health care facilities for covered services rendered to eligible individuals;

(2) to fund capital expenditures for eligible health care providers and health care facilities for approved capital investments in excess of a threshold amount to be determined annually by the executive director;

(3) to pay for preventive care, education, outreach, and public health risk reduction initiatives, not to exceed 5% of Trust income in any fiscal year;

(4) to supplement other sources of financing for education and training of the health care workforce, not to exceed 2% of Trust income in any fiscal year;

(5) to supplement other sources of financing for medical research and innovation, not to exceed 1% of Trust income in any fiscal year;

(6) to supplement other sources of financing for training and retraining programs for workers in the health care sector displaced as a result of administrative streamlining gained by moving from a multi-payer to a single payer health care system, not to exceed 2% of Trust income in any fiscal year; provided, however, that such funding shall end June 30 of the third year following full implementation of this chapter;

(7) to fund a reserve account to finance anticipated long-term cost increases due to demographic changes, inflation or other foreseeable trends that would increase Trust Fund liabilities, and for budgetary shortfall, epidemics, and other extraordinary events, not to exceed 1% of Trust income in any fiscal year; provided, however, that the Trust reserve account shall at no time constitute more than 5% of total Trust assets;

(8) to pay the administrative costs of the Trust which, within two years of full implementation of this chapter shall not exceed 5% of Trust income in any fiscal year.

Unexpended Trust assets shall not be deemed to be 'surplus' funds as defined by chapter twenty-nine of the General Laws.

Section 21.

Funding sources.

The Trust shall be the repository for all health care funds and related administrative funds. The sources of Trust funding shall include the following:

(1) All monies saved by:

(a) simplifying administration of health care finance,

(b) achieving bulk purchase discounts on pharmaceuticals and medical supplies, and

(c) early detection and intervention for health problems through timely, universally available primary and preventive care;

(2) All monies the commonwealth currently appropriates to pay for health care services or health insurance premiums, including but not limited to, all current state programs which provide covered benefits and appropriations to cities, towns and other governmental subdivisions to pay for health care services or health insurance premiums; provided, however, that the Trust shall then assume responsibility for all benefits and services previously paid for by the commonwealth with these funds. All current state health care programs which provide covered benefits shall be included in this requirement. The executive director shall seek from the Legislature a contribution for health care services that shall not decrease in relation to state government expenditures of health care services in the year that this chapter is enacted.

(3) All monies collected by cities, towns and other governmental subdivisions to pay for health care services or health insurance premiums; provided, however, that the Trust shall then assume responsibility for all benefits and services previously paid for by those governmental subdivisions with these funds.

(4) All monies the commonwealth receives from the federal government to pay for health care services or health insurance premiums; provided, however, that the commonwealth shall then assume responsibility for all benefits and services previously paid by the federal government with these funds. The Trust shall seek to maximize all sources of federal financial support for health care services in Massachusetts. Accordingly, the executive director shall obtain waivers, exemptions, agreements, or legislation, if needed, so that all current federal payments for health care shall, consistent with the federal law, be paid directly to the Trust Fund. In obtaining the waivers, exemptions, agreements, or legislation, the executive director shall seek from the federal government a contribution for health care services in Massachusetts that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation. If, and to the extent that, federal law and regulations, waivers, exemptions, agreements, or legislation allow the transfer of Medicaid and Medicare funding into the Trust, any premiums, deductibles payments, and co-insurance for qualified Medicaid and Medicare beneficiaries shall be paid by the Trust for all individuals eligible for both the Trust and federal insurance programs.

(5) All monies collected from taxes imposed on items that contribute to increased health care costs. Surtaxes, to be determined by the Legislature, in consultation with the executive director of the Trust, shall be imposed on products and facilities to the extent that they can be determined to contribute to the health care costs of the commonwealth. These may include, but shall not be limited to: alcohol, gasoline, firearms, and facilities operating in the commonwealth that generate air and/or water pollution.

(6) All monies collected through payment by all employers in the commonwealth of a Health Trust premium, based on their payroll, starting with the enactment of the benefit plan of the Trust, as determined by the Trust in consultation with the Department of Revenue. The amount of this premium shall be in line with, or less than, the average contributions that employers make toward employee health benefits as of the effective date of this act, adjusted to a rate less than national health care inflation or deflation. The premium shall be collected through the current state income tax system for deposit in the Trust Fund.

Any employer which has a contract with an insurer, health services corporation or health maintenance organization to provide health care services or benefits for its employees, which is in effect on the effective date of this section, shall be entitled to an income tax credit against premiums otherwise due in an amount equal to the Health Trust premium due pursuant to this section.

Any insurer, health services corporation, or health maintenance organization which provides health care services or benefits under a contract with an employer which is in effect on the effective date of this act shall pay to the Trust Fund an amount equal to the Health Trust premium which would have been paid by the employer if the contract with the insurer, health services corporation or health maintenance organizations were not in effect. For purposes of this section, the term ‘insurer’ includes union health and welfare funds and self-insured employers.

An employer may agree to pay all or part of the employee’s Health Trust premium imposed by the provisions of this section. Such payment shall not be considered income for Massachusetts income tax purposes.

(7) All monies collected through payment of a Health Trust premium by all individuals and families in the commonwealth. Starting with the enactment of the benefit plan of the Trust, families and individuals receiving covered benefits under the Trust shall contribute premiums on a sliding scale as determined by the Trust in consultation with the Department of Revenue. There shall be no premiums for families or individuals with income below three hundred percent of federal poverty level guidelines. The premium for employed workers shall be negotiated to be less than the amount such an individual or family would pay through an employer or private insurance plan for a comparable benefits package.

The premium shall be collected through the current state income tax system for deposit in the Trust Fund.

(8) The Trust shall retain:

(a) all charitable donations, gifts, grants or bequests made to it from whatever source consistent with state and federal law;

(b) payments from third party payers for covered services rendered by eligible providers to non-eligible patients but paid for by the Trust;

(c) income from the investment of Trust assets, consistent with state and federal law.

(9) All monies from collateral sources of payment for health care services.

It is the intent of this act to establish a single public payer for all health care in the commonwealth. However, until such time as the role of all other payers for health care has been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

As used in this section, collateral source includes all of the following:

(a) insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance;

(b) health care service plans and pension plans;

(c) employers;

(d) employee benefit contracts;

(e)government benefit programs;

(f) a judgment for damages for personal injury;

(g) any third party who is or may be liable to an individual for health care services or costs;

As used in this section, collateral sources does not include either of the following:

(a) a contract or plan that is subject to federal preemption;

(b) any governmental unit, agency, or service, to the extent that subrogation is prohibited by law.

An entity described as a collateral source is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a governmental unit, agency, or service.

The executive director shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in Massachusetts into the Trust.

Whenever an individual receives health care services under the system and she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, s/he shall notify the health care provider or facility and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider or facility shall forward this information to the executive director. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the executive director.

The Trust shall seek reimbursement from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover the costs to the Trust. Upon demand, the collateral source shall pay to the Trust Fund the sums it would have paid or expended on behalf of the individuals for the health care services provided by the Trust.

If a collateral source is exempt from subrogation or the obligation to reimburse the Trust as provided in this section, the executive director may require that an individual who is entitled to medical services from the collateral source first seek those services from that source before seeking those services from the Trust.

To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the Trust to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the Trust.

Default, underpayment, or late payment of any tax, premium, or other obligation imposed by the Trust shall result in the remedies and penalties provided by law, except as provided in this section.

Eligibility for benefits shall not be impaired by any default, underpayment, or late payment of any tax, premium, or other obligation imposed by the Trust.

Section 22.

Insurance reforms.

Insurers regulated by the division of insurance are prohibited from charging premiums to eligible participants for coverage of services already covered by the Trust. The commissioner of insurance shall adopt, amend, alter, repeal and enforce all such reasonable rules and regulations and orders as may be necessary to implement this section.

Section 23.

Health Trust regulatory authority.

The Trust shall adopt and promulgate regulations to implement the provisions of this chapter. The initial regulations may be adopted as emergency regulations but those emergency regulations shall be in effect only from the effective date of this chapter until the conclusion of the transition period.

Section 24.

Implementation of the Health Care Trust.

Not later than thirty days after enactment of this legislation, the governor shall make the initial appointments to the board of the Massachusetts Health Care Trust. The first meeting of the trustees shall take place within sixty days of enactment of this legislation.

The Trust shall complete its period of transition within three years of enactment of this legislation. Full implementation of the benefit plan of the Trust shall be completed within five years of enactment of this legislation".
The amendment was *rejected*.

Ms. Fargo and Ms. Chandler moved that the bill be amended by striking out section 4 and inserting in place thereof the following section:—

"SECTION 4. The board shall contract with an independent organization to provide the board with technical assistance related to its duties including, but not limited to, development and maintenance of the internet site and the reporting plan required pursuant to section f5. The independent organization shall have a history demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to cost and quality; (ii) identify through data analysis quality improvement areas; (iii) work with Medicare, MassHealth, other payers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; (v) establish and maintain security measures necessary to preserve the data; (vi) design and implement health care quality improvement interventions with health care service providers; (vii) identify and, when necessary, develop appropriate measures of cost and quality for inclusion on the website; and (viii) present data on the internet site in a format understandable to consumers. To the extent possible, the organization shall collaborate with other organizations that develop, collect and publicly report cost and quality measures."
After remarks, the amendment was adopted.

Mr. Barrios moved that the bill be amended by inserting, at the end thereof, the following new section:—

"SECTION 49. Chapter 149 of the General Laws is hereby amended by inserting, after section 129D, the following new section:—

Section 129E. (a) As used in this section, the following words shall have the following meanings:—

‘Health care employer’, any individual, partnership, association, corporation or, trust or any person or group of persons employing five or more employees.

‘Employee’, an individual employed by a health care facility; including any hospital, clinic, convalescent or nursing home, charitable home for the aged, community health agency, or other provider of health care services licensed, or subject to licensing by, or operated by the department of public health; any state hospital operated by the department; any facility as defined in section three of chapter one hundred and eleven B; any private, county or municipal facility, department or unit which is licensed or subject to licensing by the department of mental health pursuant to section nineteen of chapter nineteen, or by the department of mental retardation pursuant to section fifteen of chapter nineteen B; any facility as defined in section one of chapter one hundred and twenty-three; the Soldiers’ Home in Holyoke, the Soldiers’ Home in Chelsea; or any facility as set forth in section one of chapter nineteen or section one of chapter nineteen B.

(b) Each health care employer shall annually perform a risk assessment, in cooperation with the employees of the health care employer and any labor organization or organizations representing the employees, all factors, which may put any of the employees at risk of workplace assaults and homicide. The factors shall include, but not be limited to: working in public settings; guarding or maintaining property or possessions; working in high-crime areas; working late night or early morning hours; working alone or in small numbers; uncontrolled public access to the workplace; working in public areas where people are in crisis; working in areas where a patient or resident may exhibit violent behavior; working in areas with known security problems and working with a staffing pattern insufficient to address foreseeable risk factors.

(c) Based on the findings of the risk assessment, the health care employer shall develop and implement a program to minimize the danger of workplace violence to employees, which shall include appropriate employee training and a system for the ongoing reporting and monitoring of incidents and situations involving violence or the risk of violence. Employee training shall include education regarding reports to the appropriate public safety official(s), body(s) or agency(s) and process necessary for the filing of criminal charges, in addition to all employer program policies. The employer program shall be described in a written violence prevention plan. The plan shall be made available to each employee and provided to an employee upon request and shall be provided to any labor organization or organizations representing any of the employees. The plan shall include: a list of the factors, which may endanger and are present with respect to each employee; a description of the methods that the health care employer will use to alleviate hazards associated with each factor, including, but not limited to, employee training and any appropriate changes in job design, staffing, security, equipment or facilities; and a description of the reporting and monitoring system.

(d) Each health care employer shall designate a senior manager responsible for the development and support of an in-house crisis response team for employee-victim(s) of workplace violence. Said team shall implement an assaulted staff action program that includes, but is not limited to, group crisis interventions, individual crisis counseling, staff victims’ support groups, employee victims’ family crisis intervention, peer-help and professional referrals.

(e) The Commissioner of Labor shall adopt rules and regulations necessary to implement the purposes of this act. The rules and regulations shall include such guidelines as the commissioner deems appropriate regarding workplace violence prevention programs required pursuant to this act, and related reporting and monitoring systems and employee training.

(f) Any health care employer who violates any rule, regulation or requirement made by the department under authority hereof shall be punished by a fine of not more than two thousand dollars for each offense. The department or its representative or any person aggrieved, any interested party or any officer of any labor union or association, whether incorporated or otherwise, may file a written complaint with the district court in the jurisdiction of which the violation occurs and shall promptly notify the attorney general in writing of such complaint. The attorney general, upon determination that there is a violation of any workplace standard relative to the protection of the occupational health and safety of employees or of any standard of requirement of licensure, may order any work site to be closed by way of the issuance of a cease and desist order enforceable in the appropriate courts of the commonwealth.

(g) No employee shall be penalized by a health care employer in any way as a result of such employee’s filing of a complaint or otherwise providing notice to the department in regard to the occupational health and safety of such employee or their fellow employees exposed to workplace violence risk factors.”
The amendment was *rejected*.

Ms. Walsh moved that the bill be amended by inserting, after the third paragraph, the following paragraph:—

“The board shall review annually the publication of the income levels for the federal poverty guidelines and recommend a schedule of a percentage of income for each 50 per cent increment of the federal poverty level at which an individual could be expected to contribute said percentage of income towards the purchase of health insurance coverage. Affordable contribution amounts shall take into account all out of pocket costs paid by enrollees, including, but not limited to, deductibles, costs for medically necessary non-covered services, co-insurance, co-pays and premiums. The board shall consider contribution schedules, such as those set for government benefits programs. In determining the affordable percentage an individual is expected to

contribute, the board shall make adjustments for Massachusetts-specific costs of living, including but not limited to the costs of housing, food, child care, health care, transportation and taxes, and shall consult with organizations that have determined economic self-sufficiency standards for Massachusetts families. The recommended schedule shall only be approved following a public notice and hearing. The recommended schedule shall be filed as legislation and shall become effective upon enactment into law no later than each December 1, beginning on December 1, 2006.".
The amendment was *rejected*.

Mr. Tisei moved that the bill be amended by inserting the following new section:—

"SECTION XX. Notwithstanding the provisions of section 5 of chapter 176J, section 3 of chapter 176M, section 2 of chapter 176N, or any other general or special law to the contrary, a carrier may not impose a pre-existing condition exclusion or waiting period for more than 3 months following an individual's effective date of coverage with respect to Trade Act/Health Coverage Tax Credit Eligible Persons."
The amendment was adopted.

Ms. Fargo moved that bill be amended in section 17, subsection (iv) by inserting, after the words "as required by USC 1395(dd)" the following words:— ", women's health care provided by clinics licensed under section 51 of Chapter 111,".
The amendment was adopted.

Ms. Fargo moved that the bill be amended in section 42 by striking out the number "11" and inserting in place thereof the following:— "12"; and by inserting, after the words "Massachusetts Association of Health Plans", the following words:— ", 1 member nominated by Planned Parenthood League of Massachusetts".
The amendment was *rejected*.

Mr. Nuciforo moved that the bill be amended in section 2A by striking out the number "16" and inserting in place thereof the following:— "18", and inserting, in line 18, after the words '"Prevention of Medical Errors, Inc.", the following:— "1 of whom shall be appointed by the Massachusetts Chapter of the National Association of Insurance and Financial Advisors; 1 of whom shall be appointed by the Massachusetts Association of Health Underwriters;" ; in section 4 by inserting in subsection 2, after the word "institute", the following:— "a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, a representative of the Massachusetts Association of Health Underwriters,"; in section 35 by striking out the word "Agents" and inserting in place thereof the following:— "Advisors, and the Massachusetts Association of Health Underwriters,"; and in Section 48, subsection (a) by striking out the number "7" and inserting in place thereof the following:— "9"; and inserting, after the word "association", the following:— "1 of whom shall represent the Massachusetts Association of Health Underwriters and 1 of whom shall represent the Massachusetts Chapter of the National Association of Insurance and Financial Advisors.".
After remarks, the amendment was adopted.

Ms. Wilkerson moved that the bill be amended by striking out section 8, and by adding the following new section:—

"SECTION 8. Chapter 111 of the General Laws is hereby amended by inserting, after section 24J, the following section:—

Section 24K. (a) The department shall, subject to appropriation, establish a community health worker outreach program to provide community-based education and health promotion activities to communities facing barriers to and disparities in health care services in the commonwealth, particularly ethnic, racial minority and immigrant persons, families and communities, and to enhance the community health worker workforce.

(b) The program shall prepare a comprehensive and aggressive outreach services plan, which shall be updated and filed with the house and senate committees on ways and means and the joint committee on health care financing annually. The plan shall identify barriers to and disparities in health care services, including cultural and language differences between health care providers and their patients, limited accessibility of health care facilities and providers, lack of transportation, inadequate understanding of Mass Health and other health care programs by eligible persons and providers who are unfamiliar with the needs of ethnic, racial minority and immigrant persons, families and communities, disparate status, service, care and treatment of minority and immigrant persons and low participation of ethnic and racial minority persons in trials and studies of diseases and ailments, which have a high and negative impact on such persons, families and communities such as, but not limited to, asthma, lactose intolerability, diabetes, breast cancer, lupus and sickle cell anemia and any other barriers and disparities, which have a high and negative impact on such persons, families and communities. The plan shall detail a strategy for providing community-based education and health promotion services to reduce such barriers and disparities and improve public health. The strategy shall include, but not be limited to:

(i) activities to bridge cultural, linguistic and logistical gaps between health care providers and communities facing such barriers and disparities, particularly minority and low-income communities;

(ii) activities to achieve increased awareness of and higher rates of enrollment in Mass Health and other health programs, including the uncompensated care pool;

(iii) activities to increase the use of primary care and reduce inappropriate use of hospital emergency rooms; and

(iv) activities to improve the health status, service, care and treatment of such persons, families and communities, including health education, information and referral services, environmental justice and other activities.

(c) The program shall establish an advisory board representing communities with high rates of un-insurance, ethnic, racial minorities and immigrant persons, families and communities facing barriers to and disparities in health care services throughout the commonwealth. The advisory board shall review the activities of the program, assist in the preparation and implementation of the comprehensive and aggressive outreach services plan, and advise the department on the activities of the program.

(d) The program shall, subject to appropriation, competitively bid for and contract with organizations providing community health outreach services to implement the plan. Preference shall be given to organizations familiar with the communities to be served and known to members of that community. The program shall institute a training curriculum and community health worker certification program for such organizations to insure high standards, cultural competency and quality of services.

(e) The program may enter into an interagency agreement with the division of medical assistance for the provision of services by the program, and shall seek maximum federal financial participation for expenditures made by the program. The division shall work cooperatively with the department to secure federal financial participation with the goal of integrating community health workers into the activities of the division, and shall report to annually the house and senate committees on ways and means and the joint committee on health care finance, the results of a study on the feasibility of incorporating community health worker services into rates paid to providers of medical benefits by the division."

After debate, the amendment was adopted.

Mr. Panagiotakos moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION___. Chapter 94E of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting, after Chapter 94E, the following new chapter:—

CHAPTER 94F.

Cigarette Enforcement.

Section 1. For purposes of this chapter, the following words shall have the following meanings:—

'Cigarette', cigarette as defined in section 1 of chapter 94E.

'Commissioner', the commissioner of the department of public health.

'Package', a pack, box, carton or container of any kind in which cigarettes are offered for sale, sold or otherwise distributed to consumers.

'Counterfeit', any unauthorized reproduction, copy, or colorable imitation offered in connection with the sale, offering for sale, or advertising of any tobacco product.

'Person', an individual, company, corporation or partnership.

Section 2. (a) It shall be unlawful for any person:

(1) to sell, distribute, acquire, hold, own, possess, transport, import or cause to be imported into or in the commonwealth for sale or distribution in the commonwealth, any cigarettes that are counterfeit or do not comply with all requirements imposed under federal law and implementing regulations, including but not limited to the requirements on the filing of ingredients lists under the federal Cigarette Labeling and Advertising Act, 15 U.S.C. section 1335a; the permanent imprinting of package warning labels in the precise format specified under the federal Cigarette 'Labeling and Advertising Act, 15 U.S.C. section 1333; the rotation of label statements under the federal Cigarette Labeling and (Advertising Act, 15 U.S.C. section 1333(c); restrictions on the importation, transfer and sale of previously exported tobacco (products pursuant to section 9302 of Public Law 105-33, the Balanced Budget Act of 1997, as amended; the requirements of Title IV of the Imported Cigarette Compliance Act of 2000; and federal trademark and copyright laws;

(2) to alter the package of any cigarettes, prior to sale or distribution to the ultimate consumer, so as to remove, conceal or obscure: (i) any statement, label stamp, sticker, or notice indicating that the manufacturer did not intend the cigarettes to be sold, distributed or used in the United States, including but not limited to labels stating 'For Export Only,' 'U.S. Tax Exempt,' 'For Use Outside U.S.,' or similar wording; or (ii) any health warning that is not the precise warning statement in the precise format

specified in the federal Cigarette Labeling and Advertising Act, 15 U.S.C. section 1333; or (3) to affix any tax stamp or meter impression required pursuant to chapter 64C to the package of any cigarettes that does not comply with the requirements set forth in clause (1) or that is altered in violation of clause (2). (b) This chapter shall not apply to cigarettes allowed to be (imported or brought into the United States for personal use, or to cigarettes sold or intended to be sold as duty-free merchandise by a duty-free sales enterprise in accordance with 19 U.S.C. section 1555(b) and any implementing regulations. However, this chapter shall apply to any such cigarettes that are brought back into the customs territory for resale within the customs territory.

Section 3. Cigarettes imported or reimported into the United States for sale or distribution under any trade name, trade dress or trademark that is the same as, or is confusingly similar to, any, trade name, trade dress or trademark used for cigarettes manufactured in the United States for sale or distribution in the United States shall be presumed to have been purchased outside of the ordinary channels of trade.

Section 4. A violation of section 2 shall constitute an unfair trade practice under chapter 93A and a person who violates section 2 shall be subject the same penalties and remedies as available under chapter 93A in addition to any penalties or remedies set forth in this chapter.

Section 5. (a) The commissioner shall enforce this chapter. At the request of the commissioner, or the commissioner's duly authorized agent, the state police and all municipal police authorities shall also enforce this chapter. The attorney general shall have concurrent jurisdiction with the prosecuting attorneys to prosecute violations of this act. (b) For the purpose of enforcing this chapter, the commissioner and any agency or department to which the commissioner dele gates enforcement responsibility under subsection (a) may request information from any state or local agency, and may share information with, and request information from, any federal, state or local agency in the United States.

Section 6. (a) The commissioner may revoke or suspend the license of any licensee under chapter 64C upon finding, after notice and a hearing, of a violation by the licensee of this chapter or any implementing regulation promulgated thereunder by the commissioner. The commissioner may also impose on any person a civil penalty in an amount not to exceed the greater of 500 per cent of the retail value, of the cigarettes involved or $5,000 upon finding a violation by such person of this chapter or any regulation promulgated thereunder.

(b) Cigarettes that are acquired, held, owned, possessed, transported in, imported into, or sold or distributed in the commonwealth in violation of this chapter shall be deemed contraband and shall be subject to seizure and forfeiture in the same manner as provided for unstamped cigarettes under section 38A of chapter 64C. Any cigarettes so seized and forfeited shall be destroyed. Such cigarettes shall be deemed contraband whether a violation of this act is knowing or otherwise.

Section 7. A person who commits any of the acts prohibited under section 2, either knowing or having reason to know he is doing so, shall be punished by a fine of not more than $5,000 or imprisonment in the state prison for not more than 5 years, or by both such fine and imprisonment."
The amendment was *rejected*.

Mr. Lees moved that the bill amended by striking out sections 13C and 13D in their entirety; and moved that the bill be further amended by striking out section 18 and inserting in place thereof the following:—

"SECTION 18. Said chapter 118G is hereby amended by inserting, after section 18A the following section:—

Section 18B. (a) The division shall, upon verification of the provisions of services and costs thereof to a patient who is a voluntarily uninsured employee or to a dependent of such a person, assess a free rider surcharge on the patient in accordance with regulations promulgated by the division.

(b) The amount of the 'free rider' surcharge on a voluntarily uninsured employee shall be not less than 30 per cent and not greater than 100 per cent of the cost of free care provided to said employee or the employee's dependent, and may include an additional surcharge for administrative expenses incurred by the division.

(c) The division shall specify by regulation appropriate mechanisms for implementing free rider surcharges on voluntarily uninsured employees. Said regulations shall include, but not be limited to, the following provisions:

(d) Appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer or a voluntarily uninsured employee, including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons.

(e) Penalties for nonpayment or late payment by the surcharged person or entity, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(f) All surcharge payments made under this section shall be deposited into Reinsurance Trust Fund, pursuant to section 2DDD of chapter 29.

(g) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

(h) No employer shall discriminate against any employee on the basis of the employee's receipt of Uncompensated Care Pool services, the employee's reporting or disclosure of his or her employer's identity and other information about the employer. Violation of this sub-section shall constitute a per se violation of Chapter 93A.

(i) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide any uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services, as provided in section 41 of chapter 268. The division shall promulgate a standard written notice form to be made available to health care providers in English and foreign languages. The form shall further include written notice of every employee's protection from employment discrimination pursuant to this section."; and by striking out section 19.

After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-seven minutes past two o'clock P.M., on motion of Mr. Lees, as follows, to wit (yeas 7 — nays 30) **[Yeas and Nays No. 188]**:

YEAS.

Brown, Scott P.	Lees, Brian P.
Hedlund, Robert L.	Tarr, Bruce E.
Joyce, Brian A.	Tisei, Richard R. **— 7.**
Knapik, Michael R.	

NAYS.

Antonioni, Robert A.	Montigny, Mark C.
Augustus, Edward M., Jr.	Moore, Richard T.
Baddour, Steven A.	Morrissey, Michael W.
Barrios, Jarrett T.	Murray, Therese
Berry, Frederick E.	Nuciforo, Andrea F., Jr.
Brewer, Stephen M.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Resor, Pamela
Creem, Cynthia Stone	Rosenberg, Stanley C.
Fargo, Susan C.	Spilka, Karen E.
Hart, John A., Jr.	Timilty, James E.
Havern, Robert A.	Tolman, Steven A.
Jehlen, Patricia D.	Tucker, Susan C.
McGee, Thomas M.	Walsh, Marian
Menard, Joan M.	Wilkerson, Dianne **— 30.**

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr.	Panagiotakos, Steven C. **— 2.**

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

Mr. Hart moved that the bill be amended by inserting, after section ___, the following new section:—

"SECTION ___. Hospital based Community Health Centers shall receive payment from the free care pool for fiscal year ending 6/30/07 at no less than they receive for fiscal year ending 6/30/06.".
The amendment was *rejected*.

Ms. Wilkerson, Mr. Barrios and Ms. Jehlen moved that the bill be amended by adding, after section 61, the following new section:—

"SECTION 62. During Pool Fiscal Years 2006 and 2007, the provisions of 114.6 CMR 10.00, 114.6 CMR 11.00 and 114.6 CMR 12.00, in effect as of September 15, 2005, shall remain in force for the Uncompensated Care Pool established pursuant to chapter 118G of the General Laws or any successor program.".

The President in the Chair, after remarks, the amendment was adopted.

There being no objection, at twenty-four minutes before three o'clock P.M., the President declared a recess subject to the call of the Chair; and, at twelve minutes past three o'clock P.M., the Senate reassembled, Mr. Havern in the Chair.

Mr. O'Leary moved to amend the bill by adding, at the end thereof, the following new section:—

"SECTION ___. Notwithstanding any general or special law to the contrary, for a geographically isolated, nonprofit nursing home located on an island in Dukes County, which is the sole community nursing home provider for the island and which is controlled by a nonprofit hospital located on said island, effective the first day that the historical rate relief previously awarded to said nursing home, which ended July 1, 2004, the Division of Health Care Finance and Policy, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, shall retroactively and prospectively establish a Medicaid rate add-on totaling $350,000 annually, to be paid on a Medicaid patient day basis.".
The amendment was *rejected*.

Mr. Panagiotakos moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Chapter 118E of the General Laws, as appearing in the most recent Official Edition, is hereby amended by inserting the following new section:—

Section 16D. Notwithstanding a member's coverage type or enrollment in a Managed Care Organization, the division shall provide reimbursement to providers for all medically necessary non-emergency ambulance and wheelchair van trips provided to enrollees in the MassHealth Basic and MassHealth Essential plans.

Medical necessity for non-emergency ambulance service shall be established by the completion of a Medical Necessity Form signed by a physician, physician's designee, physician assistant, nurse midwife, dentist, nurse practitioner, managed care representative, or registered nurse. The member's record must support the information given on the Medical Necessity Form. The transportation provider is responsible for the completeness of the Medical Necessity Forms. The completed Medical Necessity Form must be kept by the transportation provider as a record for four years from the date of service."

Pending the question on adoption of the amendment at fourteen minutes past three o'clock P.M., Mr. Lees doubted the presence of a quorum; and, a count of the Senate determined that a quorum was present.

Subsequently, after remarks, the amendment was adopted.

Mr. Barrios moved that the bill be amended by adding the following new section:—

"SECTION ___. Subsection (2) of section 9A of chapter 118E of the General Laws, as so appearing, is further amended, in line 115, by striking out the figure '133' and inserting in place thereof the following figure:— 200".
After remarks, the amendment was adopted.

Messrs. Tisei and Brown moved that the bill be amended by inserting the following new section:—

"SECTION XX. The secretary of the executive office of health and human services shall conduct a study to determine the costs of allowing primary care givers who care for elderly parents or immediate family members who are disabled on a full-time basis to obtain MassHealth benefits. The secretary shall submit this report no later than July 1, 2006 and shall submit said report to the senate president, senate minority leader, chairman of the senate ways and means committee, speaker of the house of representatives, house minority leader and chairman of the house ways and means committee."
After remarks, the amendment was adopted.

Ms. Resor, Ms. Jehlen and Mr. Tisei moved that the bill be amended by adding the following new section:—

"SECTION ___. Clause (h) of subsection (2) of section 9A of chapter 118E of the General Laws is hereby amended by adding the following:— provided that the division shall not establish disability criteria for applicants or recipients which are more restrictive than those criteria authorized by Title XVI of the Social Security Act, 42 USC section 1381 et seq."
After remarks, the amendment was adopted.

Mr. Lees moved that the bill be amended by striking out section 13 in its entirety.
The amendment was *rejected*.

Mr. Lees moved that the bill be amended by striking out section 52 in its entirety.
The amendment was *rejected*.

Mr. Lees moved that the bill be amended by striking out section 51 in its entirety.

After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-nine minutes past three o'clock P.M., on motion of Mr. Lees, as follows, to wit (yeas 6 — nays 32) **[Yeas and Nays No. 189]**:

YEAS.

Brown, Scott P.	Lees, Brian P.
Hedlund, Robert L.	Tarr, Bruce E.
Knapik, Michael R.	Tisei, Richard R. **— 6.**

NAYS.

Antonioni, Robert A.	Montigny, Mark C.
Augustus, Edward M., Jr.	Moore, Richard T.
Baddour, Steven A.	Morrissey, Michael W.
Barrios, Jarrett T.	Murray, Therese
Berry, Frederick E.	Nuciforo, Andrea F., Jr.
Brewer, Stephen M.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Timilty, James E.
Jehlen, Patricia D.	Tolman, Steven A.
Joyce, Brian A.	Tucker, Susan C.
McGee, Thomas M.	Walsh, Marian
Menard, Joan M.	Wilkerson, Dianne **— 32.**

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr.
— 1.

The yeas and nays having been completed at twenty-eight minutes before four o'clock P.M., the amendment was *rejected*.

Mr. Nuciforo moved that the bill be amended in section 40 by inserting, after the words "in effect for the previous fiscal year", the following:— "; provided, however, that in areas where the department of public health has made a determination that there is a shortage of obstetricians, fees for obstetricians shall be adjusted upward by an amount equal to not less than 14 per cent of the fees in effect for the previous fiscal year".
The amendment was *rejected*.

Ms. Menard moved that the bill be amended in section 56 by adding the following sentence:— "The executive office of health and human services shall make provisions to allow those persons enrolled in said program and meeting the eligibility requirements established under the MassHealth program to be eligible to enroll in Medicaid managed care organizations and to allow the Medicaid managed care organizations the option of enrolling program members through current managed care organization enrollment assignment guidelines.".
The amendment was *rejected*.

Mr. Lees moved that the bill be amended by inserting the following section:—

“SECTION ___. There is hereby established within the health safety net fund, a MassHealth provider payment account, administered by the secretary of the executive office of health and human services. Subject to the availability of federal financial participation, funds may be expended from this account for supplemental Medicaid rate payments and safety net care payments to qualifying providers.”; and by inserting the following:—

“SECTION ___. The Comptroller shall transfer $251,000,000 from the general fund to the MassHealth provider payment account within the health safety net fund established in section ___.”.
The amendment was *rejected*.

Ms. Tucker moved that the bill be amended by inserting, at the end thereof, the following new section:—

“SECTION ___. Notwithstanding the provisions of any general or special law to the contrary, 440 million dollars shall be transferred from the Commonwealth Care Fund to the Health Safety Net Trust Fund in fiscal year 2007; provided further, that of this amount 70 million dollars shall be used for transitional reimbursement payments to the 2 disproportionate share hospitals, as defined by section 1 of chapter 118G with the highest relative volume of free care costs for hospital year 2007 as determined by the health safety net office, and that this reimbursement shall be separate from any other reimbursements authorized by the health safety net office, and provided that 30 million dollars shall be used for transitional reimbursement payments to the 12 disproportionate share hospitals, as defined by section 1 of chapter 118G, with the next highest volume of free care costs in that year, and that these reimbursements shall be separate from any other reimbursements authorized by the health safety net office.”.
The amendment was *rejected*.

Mr. Tarr moved that the bill be amended by inserting, at the end thereof, the following 2 sections:—

“SECTION XXX. Section 51G of Chapter 111 of the General Laws is hereby amended in Subsection (4) by adding, after the first sentence, the following:—

Any such notification shall include, but not be limited to, the following:

1. The reasons for which the closing or discontinuance is being proposed.

2. An analysis of the economic feasibility of retaining the essential health service or hospital and the economic impacts of the proposed closing or discontinuance.

3. An analysis of the clinical safety of retaining the essential health service or hospital and any threats to public health and safety that would be caused by the proposed closing or discontinuance.

SECTION XXX. Section 51G of Chapter 111 of the General Laws is hereby amended in Subsection (4) by adding, after the word ‘hospital’ in the fourth sentence thereof the following:—

The department may, if it determines that an essential health service can be retained in a clinically safe manner without depriving the hospital of a fair net operating income, deny the proposed discontinuance and require the retention of the essential health service either in its original condition or any modification which the department deems to be satisfactory.

In the event that a hospital proposed for closure is owned or controlled by an entity which holds a license for facilities other than the hospital proposed for closure, and the department determines that the hospital can be retained in a clinically safe manner and without depriving that entity of a fair net operating income, the department may require the retention of said hospital either in its original configuration or any modification which the department deems to be satisfactory.”
The amendment was *rejected*.

Ms. Tucker moved that the bill be amended by inserting, at the end thereof, the following new section:—

“SECTION ___. The Division of Medical Assistance is hereby authorized and directed to conduct a pilot program to provide Explanation of Benefit receipts to a sample of Mass Health beneficiaries following services rendered.”.

After remarks, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-two minutes before four o’clock P.M., on motion of Mr. Lees, as follows, to wit (yeas 38 — nays 0) **[Yeas and Nays No. 190]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.

Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at eighteen minutes before four o'clock P.M., the amendment was adopted.

Ms. Resor and Mr. McGee moved that the bill be amended in section 22 by adding at the end of section 111I, subsection (b) number (5) the following:— " (6) diabetes related services, medications, and supplies as defined in Massachusetts General Laws Chapter 175 section 47N"; and further in section 23 by adding at the end of section 1E subsection (b) number (5) the following:— "(6) diabetes related services, medications, and supplies as defined in MGL Chapter 176A section 8P"; and further in section 26 by adding at the end of section 6C subsection (b) number (5) the following:— "(6) diabetes related services, medications and supplies as defined in MGL Chapter 176B section 4S"; and further in section 28 by adding at the end of section 16B subsection (b) number (5) the following:— "(6) diabetes related services, medications and supplies as defined in MGL Chapter 176G section 4H.".
The amendment was adopted.

Messrs. Panagiotakos, Tarr and Joyce moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Notwithstanding anything in this Act to the contrary, nothing in this Act shall interfere with a person's right to receive chiropractic benefits in accordance with the provisions of Chapter 175, section 108D."
The amendment was *rejected*.

Mr. O'Leary moved that the bill be amended by striking out section 10.
The amendment was *rejected*.

Mr. O'Leary moved that the bill be amended in section 47, clause (2), by striking out the words "based on" and replacing it with the following words:— "equal to"; by striking out the words "a similarly situated"; and by striking out the word "hospital" and replacing it with the following word:— "hospitals".
The amendment was *rejected*.

Mr. O'Leary moved that the bill be amended in section 47, clause (3), by inserting the following words:— "(4) participate in the provider assessment of the UCP under the rules and regulations for acute care hospitals or its subsequent form.".
The amendment was *rejected*.

Mr. O'Leary moved that the bill be amended in section 47 by striking out the words "shall not require a determination of need by the department of need by the department of public health under Section 51 of Chapter 111 or Sections 25B through 25G of Chapter 111, as so appearing" and replacing it with the following words:— "shall be required to obtain a determination of need by the department of public health under Section 51 of Chapter 111 or Sections 25B through 25G of Chapter 111, as so appearing, but only if and to the extent that any acute care hospitals in the same service areas as said center would be required to

obtain such a determination of need,".
The amendment was *rejected*.

Ms. Tucker and Ms. Chandler moved that the bill be amended by striking out section 9 in its entirety; and by further striking out section 47 in its entirety.
The amendment was *rejected*.

Mr. Tolman moved that the bill be amended in section 22 by adding the following:—

"(b)(3)(i) qualified clinical trials as set forth in section 110L;

and further amended, in section 23, by adding the following:

(b)(3)(i) qualified clinical trials as set forth in section 8W;

and further amended, in section 26, by adding the following:

(b)(3)(i) qualified clinical trials as set forth in section 4W;

and further amended, in section 28, by adding the following:

(b)(3)(i) qualified clinical trials as set forth in section 4O;".
The amendment was *rejected*.

Mr. Tolman moved that the bill be amended in section 42, paragraph (a), by striking out the number "11" and inserting the following:— "12"; and adding after the words "Massachusetts Association of Health Plans" the following new words:— "1 member nominated by the Massachusetts Association of Behavioral Health Systems".
After remarks, the amendment was adopted.

Mr. Tolman moved that the bill be amended, in sections 22, 23, 26 and 28, paragraph (b), by adding the following new subsection:—

"(6) substance abuse services; provided however, that notwithstanding the provisions of any general or special law to the contrary, the commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not provide coverage for substance abuse services under the same terms and conditions, including any annual or lifetime dollar or unit of service limitations, co-payments, or deductibles, as provided for covered benefits for the treatment and diagnosis of physical illnesses".
The amendment was *rejected*.

Messrs. Tolman and Barrios moved that the bill be amended by striking out section 46 and inserting in place thereof the following:—

"Section 4 of Chapter 32B is hereby amended by inserting, at the end thereof, the following sentence:— An employee, who elects to forego coverage under the employer's group health insurance plan pursuant to this section and receives services through the uncompensated care pool or Medicaid, shall be considered a voluntarily uninsured employee for purposes of Chapter 118G.".
The amendment was *rejected*.

Mr. Tolman moved that the bill be amended by striking out section 10.
The amendment was *rejected*.

The President in the Chair, Ms. Wilkerson moved that the bill be amended in section 2A by adding, after the words "acts of 2005", the following:— "one member representing the Massachusetts Community Health Worker Network".
After remarks, the amendment was adopted.

Mr. Barrios moved that the bill be amended by striking out section 18 and inserting in place thereof the following section:—

"SECTION 18. Said chapter 118G is hereby amended by inserting, after section 18A the following section:—

Section 18B. (a) The division shall, upon verification of the provision of services and costs to a patient who works for a non-providing employer or to a dependent of such person, assess a free rider surcharge on the non-providing employer in accordance with regulations promulgated by the division.

(b) The amount of the free rider surcharge on non-providing employers shall be not less than 100 per cent and not greater than 150 per cent of the cost of free care provided to said employer's employee or the employee's dependent, and may include an additional surcharge for administrative expenses incurred by the division.

(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the division that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services from the uncompensated care pool or Medicaid, pursuant to Chapter 118E of the General Laws; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees for whom the non-providing employer provides health insurance.

(d) The division shall, upon verification of the provisions of services and costs thereof to a patient who is a voluntarily uninsured employee or to a dependent of such a person, assess a free rider surcharge on the patient in accordance with regulations promulgated by the division.

(e) The amount of the 'free rider' surcharge on a voluntarily uninsured employee shall be not less than 30 per cent and not greater than 100 per cent of the cost of free care provided to said employee or the employee's dependent, and may include an additional surcharge for administrative expenses incurred by the division.

(f) The formula for assessing 'free rider' surcharges on voluntarily uninsured employees shall be set forth in regulations promulgated by the division that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which the employee received services from the uncompensated care pool or Medicaid, pursuant to Chapter 118E of the General Laws ; (ii) the gross annual income of the employee's family; (iii) the total assets of the employee's family.

(g) If the person or employee is employed by more than one non-providing employer at the time he or she receives services, the division shall assess a free rider surcharge on each said employer consistent with the formula established pursuant to this section. If a dependent, at the time he or she receives services, is the dependent of a person or employee or persons or employees employed by more than one non-providing employer, the division shall assess a free rider surcharge on each said employer consistent with the formula established pursuant to this section.

(h) The division shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers and voluntarily uninsured employees. Said regulations shall include, but not be limited to, the following provisions:

(i) Appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer or a voluntarily uninsured employee, including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons.

(j) Penalties for nonpayment or late payment by the surcharged person or entity, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(k) All surcharge payments made under this section shall be deposited into Reinsurance Trust Fund, pursuant to section 2DDD of chapter 29.

(l) A non-providing employer's liability to said pool shall in the case of a transfer of ownership be assumed by the successor in interest to the non-providing employer's.

(m) Any non-providing employer that fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the division or which falsifies the same, shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(n) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

(o) No employer shall discriminate against any employee on the basis of the employee's or their dependent's receipt of Uncompensated Care Pool services, the employee's reporting or disclosure of his or her employer's identity and other information about the employer, the employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to 'free rider' surcharges assess against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of Chapter 93A.

(p) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide any uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services, as provided in section 41 of chapter 268. The division shall promulgate a standard written notice form to be made available to health care providers in English and other languages. The form shall further include written notice of every employee's protection from employment discrimination pursuant to this section and a list of health insurance options available to voluntarily uninsured employees."
After remarks, the amendment was adopted.

Messrs. Tarr, Montigny and Hedlund moved that the bill be amended by inserting, at the end thereof, the following section:—

"SECTION XXX. Notwithstanding any general or special law to the contrary there shall be a demonstration program pertaining to health care coverage for fishermen administered by the Health Safety Net Office."
The amendment was adopted.

Mr. O'Leary moved that the bill be amended by inserting, at the end thereof, the following new section:—

"SECTION ___. Section 2 of chapter 32B of the General Laws, as appearing in the 2002 Official Edition, is hereby amended, in line 61, by inserting, after the word 'commonwealth', the following words:— , and the Wampanoag Tribe of Gay Head (Aquinnah) a federally recognized Indian Tribe as referenced in 25 U.S. Code section 1771 et. seq.".

After debate, the amendment was adopted.

Mr. Panagiotakos moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Notwithstanding anything in this Act to the contrary, nothing in this Act shall interfere with a person's right to receive chiropractic benefits in accordance with the provisions of Chapter 175, section 108D."
The amendment was adopted.

Ms. Chandler and Mr. Joyce moved that the bill be amended by inserting, after section 34, the following new section:—

"SECTION 34A. Chapter 118E of the General Laws is hereby amended by striking out section 33 and inserting in place thereof the following new section:—

Section 33. No claim for costs of a nursing facility and other long-term care services may be made by the division under section 31 or 32 if the individual receiving medical assistance was permanently institutionalized, had notified the division that he had no intent on returning home, and had on the date of admission to the nursing facility or other medical institution long-term care insurance that when purchased met the requirements of 211 C.M.R. 65.00.".

After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at three minutes past four o'clock P.M., on motion of Ms. Chandler, as follows, to wit (yeas 37 — nays 0) **[Yeas and Nays No. 191]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	Pacheco, Marc R.
Buoniconti, Stephen J.	Panagiotakos, Steven C.
Chandler, Harriette L.	Resor, Pamela
Creem, Cynthia Stone	Rosenberg, Stanley C.
Fargo, Susan C.	Spilka, Karen E.
Hart, John A., Jr.	Tarr, Bruce E.
Havern, Robert A.	Timilty, James E.
Hedlund, Robert L.	Tisei, Richard R.
Jehlen, Patricia D.	Tolman, Steven A.
Joyce, Brian A.	Tucker, Susan C.
Knapik, Michael R.	Walsh, Marian
Lees, Brian P.	Wilkerson, Dianne — **37.**
McGee, Thomas M.	

NAYS — 0.
ABSENT OR NOT VOTING.
Creedon, Robert S., Jr O'Leary, Robert A. — **2.**

The yeas and nays having been completed at eight minutes past four o'clock P.M., the amendment was adopted.

Mr. Pacheco moved that the bill be amended by inserting the following new language:—

"SECTION ___. Said chapter 112 is hereby amended by inserting, after section 2, as so appearing, the following new paragraphs:—

The board of registration in medicine shall grant or renew a certificate of registration without payment of a fee by a physician qualified for registration or renewal of the same under this chapter in order for the physician to participate in the free care program operated by a non-profit organization. The scope of practice of physicians whose certificates of registration are granted or renewed pursuant to this paragraph may be restricted as the board may provide by regulation. Notwithstanding any law or regulation to the contrary, physicians licensed to provide voluntary care shall not be required to carry medical malpractice insurance coverage for such care, but shall be subject to all other requirements the board has established or established for physicians concerning quality of care, continuing education requirements and competence to practice medicine. The board shall promulgate said regulations no later then three months after the effective date of this act.

Section___. The Commissioner of Public Health, or his designee, is hereby requested to study the impact of the Federal Volunteer Protection Act of 1997 on health care volunteers in Massachusetts. The Commissioner is requested to review ways in which the Commonwealth may act to provide legal counsel and defense to volunteers who may be eligible for the protections afforded in the Volunteer Protection Act. The Commissioner is requested to report back to the Joint Committee on Health Care with his recommendations by December 31, 2006."
The amendment was adopted.

Mr. Pacheco moved that the bill be amended by inserting the following new language:—

"SECTION ___. The general court finds it to be in the interest of the commonwealth to promote the prevention of injury and illness of residents.

Whereas, There are individuals and families residing in the commonwealth who lack health insurance coverage for preventative health or primary care services, utilization of said services has been shown to be effective in reducing the incidence of preventable hospitalization and cost of health care, there are a significant number of students of the medical and health sciences and licensed and certified health professionals located in the commonwealth seeking opportunities to service the public in community settings, there are a number of health programs and facilities in the commonwealth that may benefit from the services of said students and health professionals, and students who participate in such programs are likely to seek careers in community settings.

Whereas, Higher education students and retired medical professionals can help address these public health needs through the creation of the Commonwealth Student Health Corps.

SECTION ___. Chapter 73 is hereby amended by inserting, after section 2A, as so appearing, the following sections:—

Section ___. The Board of Higher Education (board) shall establish the Commonwealth Student Health Corps to expand opportunities for students of public health and medical professions, practitioners, and active and retired certified professionals to participate in public service programs that help meet critical community needs. The board shall develop a program to expand and coordinate public and private resources that promote community service by coordinating supervised students with professionals in public health service programs.

The board shall establish, as part of the Commonwealth Student Corps, a curriculum based community service-learning requirement for all students enrolled in approved Massachusetts public colleges and universities. The board shall adopt guidelines and deadlines governing the implementation of such a program, including the selection of criteria, requirements and hours necessary for students to meet said requirement.

The board shall work in cooperation with the Massachusetts Service Alliance (Alliance), the national and state commission on service, to ensure students are matched with accredited service sites. The Alliance shall develop criteria for the accreditation of said service sites.

The purpose and goals of the curriculum based community service-learning requirement for students is to:

(1) increase opportunities for students throughout Massachusetts to participate in real world applied learning through curriculum based service-learning activities;

(2) help improve the state's public health needs;

(3) strengthen communities through service;

(4) enhance the ethic of service.

The board, with the alliance, shall have the responsibility and authority to:

(1) conduct studies and accredited projects;

(2) apply to private sources and federal government for grants to implement studies and accredited service projects; deposit funds and received from those sources in a separate account at the department of each state college or university; and expend such funds for the purpose set forth in this section;

(3) enter into agreements with each other and other entities as allowed by law for the purposes of implementing this act;

(4) study of the feasibility of utilizing the services of retired professionals and other licensed and certified professionals;

(5) deliver reports of the program to the governor and the general court as appropriate;

(6) implement statewide Commonwealth Student Corps programs designed to achieve the comprehensive and coordinated delivery of services to underserved and underinsured populations and geographical areas; and

(7) appoint a program director to implement and administer the studies and accredited service projects initiated by this chapter.

SECTION ___. The board shall promulgate regulations to implement a curriculum based community service-learning requirement for medical and public health students on or before August 1, 2007.

SECTION ___. The board shall promulgate regulations to develop a Commonwealth Student Health Corps on or before August 1, 2007.

SECTION ___. A member of the Commonwealth Student Corps shall not be considered an employee of the commonwealth entitled to benefits such as worker's compensation or unemployment benefits, nor shall a member be considered to be an employee of the commonwealth. A municipality shall not be held liable for any claim arising out of a community service program. Service opportunities shall not replace existing state employees."
The amendment was adopted.

Ms. Chandler moved that the bill be amended by inserting, after section ___, the following new section:—

"SECTION ___. A managed care organization, as defined in 130 CMR 501.001, which maintains National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line, shall be deemed complaint by the office of Medicaid for all standards within the categories for which the Managed Care Organization (MCO) has been surveyed and determined to meet all standards. Accredited MCO's will be required to provide quarterly, semi-annual and annual reporting as required per contract.".
After remarks, the amendment was adopted.

Ms. Spilka, Messrs. Nuciforo and Brewer, Ms. Chandler, Ms. Resor and Messrs. Tarr, Montigny, Tisei, Tolman, Brown and Joyce moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Chapter 176O of the General laws is hereby amended by adding, after section 5, the following new section:—

Section 5A. Contracts between carriers and health care providers shall require the exclusive use of Medicare coding standards and guidelines for patient diagnostic information and patient service and procedure information as described and updated from time to time under Title XVIII of the federal Social Security Act. Contracts between carriers and health care providers shall also require the exclusive use of the standardized paper claim forms and electronic claim formats utilized by Medicare as described and updated from time to time under Title XVIII of the federal Social Security Act.

Changes to Medicare coding standards and guidelines for patient diagnostic information and patient service and procedure information shall be adopted in their entirety by carriers and health care providers within 30 days of publication by the Centers for Medicare and Medicaid Services. Changes to Medicare claim forms and formats shall be accepted and routinely processed by carriers and health care providers within 30 days of publication by the Centers for Medicare and Medicaid Services.

The commissioner shall consult with interested parties, including but not limited to, the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Behavioral Health Systems, the Massachusetts Association of Health Plans (MAHP) and one state licensed insurance plan that that is not a member of the MAHP, prior to developing regulations required under this section.

The commissioner shall promulgate regulations implementing this section by April 1, 2006 and shall further require that all contracts between a carrier and a health care provider reflect the provisions of this section by October 1, 2007.

After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at sixteen minutes past four o'clock P.M., on motion of Mr. Tarr, as follows, to wit (yeas 38 — nays 0) **[Yeas and Nays No. 192]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at nineteen minutes past four o'clock P.M., the amendment was adopted.

Mr. Pacheco and Ms. Fargo moved that the bill be amended by adding the following new sections:—

"SECTION ___. Said chapter 112 is hereby amended by inserting, after section 45A, as so appearing, the following section:—

Section 45B. (a) The board may grant or renew a certificate of registration without payment of a fee to a dentist qualified for registration or renewal of the same under this chapter; provided, that the dentist has agreed to restrict his practice to that of a volunteer practitioner in a specified free care program operated by a nonprofit organization. The scope of practice of a dentist whose certificate of registration is granted or renewed pursuant to this section may be restricted as the board may provide by regulation.

(b) In order to qualify for a license for volunteer practice, an applicant shall meet the requirements for a regular license under this chapter, in addition to the requirements set forth below. An applicant shall submit to the board a completed application on a form prescribed by the board and any additional information that the board requests. An applicant shall agree to the conditions on practice promulgated by the board.

(c) The board's application form for a license for volunteer practice shall include a request for the following information:

(1) a written statement from the applicant outlining the scope and duration of services to be provided by the applicant;

(2) a written statement from the director of the applicant's proposed work site outlining the scope and duration of the applicant's responsibilities; and

(3) evidence satisfactory to the board that, in the proposed work site, the volunteer dentist will be serving without compensation and providing free dental care to a low-income community, or a community with limited access to dental care.

(d) If an applicant has met all of the requirements of this section to the satisfaction of the board, the applicant shall be granted a license for volunteer practice and entitled to a certificate of registration signed by the chairman and the secretary of the board. A licensee engaged in volunteer practice may practice dentistry only at a work site approved in conjunction with his license application; shall be subject to the same conditions and responsibilities as a regular licensee; and may not accept any compensation for the practice of dental medicine.

SECTION ___. The board of registration in dentistry shall promulgate regulations to carry out section 2 not later than 3 months following the effective date of this act.

SECTION ___. The commissioner of public health, or his designee, shall study the impact of the Federal Volunteer Protection Act of 1997 and the Free Clinics Federal Tort Claims Act Medical Malpractice Program on health care volunteers in the commonwealth. The commissioner shall review ways in which the commonwealth may act to provide legal counsel and defense to volunteers who may be eligible for the protections afforded in the Volunteer Protection Act of 1997 or the Free Clinics Federal Tort Claims Act Medical Malpractice Program. The commissioner shall report the results of the review by filing the same with the joint committee on health care, together with recommendation for legislation, if any, by December 31, 2005."
The amendment was adopted.

Mr. Barrios moved that the bill be amended by inserting, after section 23, the following section:—

"SECTION 24. Notwithstanding the provisions of section 11H of chapter 175, section 1E of chapter 176A, section 6C of chapter 176B, and section 16A of chapter 176G, or the provisions of any other general or specific law to the contrary, the commission shall not purchase any policy of insurance or enter into any contract for the service of a health care organization which does not provide for all mandated benefits required by chapters 175, 176A, 176B and 176G of the General Laws; and further provided, that the commission shall not enter into any contract for the services of a health care organization which contains any of the provisions described in section 16A of chapter 176G."
The amendment was adopted.

Ms. Tucker, Ms. Jehlen, Messrs. Joyce, Barrios, Havern, Tisei, Ms. Resor, Ms. Fargo and Mr. Brown moved that the bill be amended by inserting, at the end thereof, the following new sections:—

"SECTION XX. Section XX of chapter one hundred and eighteen E is hereby amended by striking out, in the second paragraph, the following sentence: 'provided, further, that said benefits shall be available to otherwise eligible persons seeking admission to and residents of long-term care facilities whose income and resources are insufficient to meet the cost of their medical care as determined by the financial eligibility requirements of said program.' and replacing it with the following new sentences: 'provided, further, that said benefits shall be available to otherwise eligible persons seeking long-term care whose income and resources are insufficient to meet the cost of their medical care as determined by the financial eligibility requirements of said program. For the purposes of this chapter, the division shall establish clinical eligibility for a long-term care benefit, so-called. Any person determined by the division as clinically eligible for said long-term care benefit shall be given the choice of care setting that is the least restrictive and most appropriate to meet his or her needs. The dollars that are provided for said long-term care benefit shall follow such individual as his or her setting of care changes.'.

SECTION XX. The division shall promulgate regulations to implement the provisions of section 1, and shall submit a section 1115(a) research and demonstration waiver no later than July 1, 2006 to implement the provisions of section 1. Said waiver shall establish an income eligibility up to 300 percent of the federal benefit rate under the supplemental security income program, and an asset test of not less than $10,000. Said waiver shall maximize the federal financial participation for all enrollees, and meet budget neutrality requirements established for such waivers.

SECTION XX. Section 9 of chapter one hundred and eighteen E is hereby further amended by adding, at the end thereof, the following new language:— 'All persons seeking admission to a long-term care facility paid for by MassHealth shall receive pre-admission counseling for long-term care services, which shall include an assessment of their community-based service options. All persons seeking care in a long-term care facility on a private pay basis shall be offered said pre-admission counseling on a voluntary basis. For the purpose of this section, all said pre-admission counseling shall be conducted by the executive office of elder affairs, or its subcontractors. The division shall report to the general court on an annual basis the number of individuals who

received pre-admission counseling under this section, and the number of diversions to the community generated by this pre-admission counseling program, so-called.’.”

After remarks, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-three minutes past four o’clock P.M., on motion of Ms. Tucker, as follows, to wit (yeas 38 — nays 0) **[Yeas and Nays No. 193]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O’Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at twenty-six minutes past four o’clock P.M., the amendment was adopted.

Messrs. Tisei and Brown moved that the bill be amended by inserting, after section 29, the following new section:—

“SECTION 29A. Section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting the following definitions:—

‘Association health plan’, a Massachusetts nonprofit or not-for-profit corporation, all the members of which are qualified associations and that negotiates with one or more carriers for the issuance of health benefit plans that cover employees of qualified association members and their dependents. To be certified by the commissioner, an association health plan must have a minimum of twenty-five qualified associations contracted to provide the plan to their members.

‘Qualified association’, a Massachusetts nonprofit or not-for-profit corporation or other entity that has been organized and maintained for purposes of advancing the occupational, professional, trade or industry interests of its members, other than that of obtaining health insurance, that has been in active existence for at least five years, that is comprised of at least 100 members, and membership in which is generally available to members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective member.

SECTION 2. Said chapter 176J, as so appearing, is hereby further amended by inserting, at the end thereof, the following new section:—

Section 11. Association Health Plan.

The commissioner shall write regulations governing the establishment and oversight of association health plans. Those regulations shall require that all state mandated benefits are required under such plans, that denial of coverage due to the health condition, age, race or sex is prohibited, and that no eligible small business who is a member of the association health plan may be charged a premium rate higher than what the carrier would charge to a similarly situated eligible small business who is not a member of the association health plan.

The commissioner shall biannually certify that an association health plan satisfies the requirements of this chapter. Only an association health plan that has been certified by the commissioner may procure health care coverage for the benefit of qualified association members.

The books and records of an association health plan and the methodology by which it confirms the status of qualified associations shall be subject to review by the commissioner.

Health care coverage procured by an association health plan may be sold only to qualified association members and shall be sold only through duly licensed agents and brokers."

Pending the question on adoption of the amendment, Messrs. Baddour, Lees, Tisei, Tarr and Brown moved that the amendment be amended by striking out the amendment and inserting the following:—

"Section 1 of Chapter 176J of the General Laws is hereby amended by inserting the following definitions:—

'Association health plan', a Massachusetts nonprofit or not-for- profit corporation all the members of which are qualified associations and that negotiates with one or more carriers for the issuance of health benefit plans that cover employees of qualified association members and their dependents. To be certified by the Commissioner, an association health plan must have a minimum of twenty-five qualified associations contracted to provide the plan to their members.

'Qualified association', a Massachusetts nonprofit or not-for-profit corporation or other entity that has been organized and maintained for purposes of advancing the occupational, professional, trade or industry interests of its members, other than that of obtaining health insurance, that has been in active existence for at least five years, that is comprised of at least 100 members, and membership in which is generally available to members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective member."; and

A new section 10 is added to Chapter 176J of the General Laws as follows:

"Section 10. Association Health Plan.

(a) The commissioner shall write regulations governing the establishment and oversight of association health plans. Those regulations shall require that all state mandated benefits are required under such plans, that denial of coverage due to the health condition, age, race or sex is prohibited, and that no eligible small business who is a member of the association health plan may be charged a premium rate higher than what the carrier would charge to a similarly situated eligible small business who is not a member of the association health plan. The Commissioner shall authorize not more than one association health plan.

(b) The commissioner shall biannually certify that an association health plan satisfies the requirements of this chapter. Only an association health plan that has been certified by the commissioner may procure health care coverage for the benefit of qualified association members.

(c) The books and records of an association health plan and the methodology which it confirms the status of qualified associations shall be subject to review by commissioner.

(d) Health care coverage procured by an association health plan may be sold only to qualified association members and shall be sold only through duly licensed agents and brokers.

(e) Eligible businesses for the association health plan shall have 10 or less employees.

(f) The Commissioner shall report on the effectiveness and business cost savings to the Committees on Senate Ways and Means and House Ways and Means as well as the Joint Committees on Health Care Financing and Financial Services within 24 months of the initial certification of the association health plan as defined under this section.

(g) This section shall expire 48 months after the initial certification of the association health plan."

After debate, the question on adoption of the further amendment was determined by a call of the yeas and the nays at four minutes past five o'clock P.M., on motion of Mr. Brown, as follows, to wit (yeas 11 — nays 27) **[Yeas and Nays No. 194]**:

YEAS.

Baddour, Steven A.	Lees, Brian P.
Brewer, Stephen M.	Morrissey, Michael W.
Brown, Scott P.	Tarr, Bruce E.
Hedlund, Robert L.	Tisei, Richard R.
Joyce, Brian A.	Tucker, Susan C. **— 11.**
Knapik, Michael R.	

NAYS.

Antonioni, Robert A.	Moore, Richard T.
Augustus, Edward M., Jr.	Murray, Therese
Barrios, Jarrett T.	Nuciforo, Andrea F., Jr.
Berry, Frederick E.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Timilty, James E.
Jehlen, Patricia D.	Tolman, Steven A.
McGee, Thomas M.	Walsh, Marian
Menard, Joan M.	Wilkerson, Dianne **— 27.**
Montigny, Mark C.	

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr.
— 1.

The yeas and nays having been completed at seven minutes past five o'clock P.M., the further amendment was *rejected*.

The pending amendment (Tisei) was then considered; and it was *rejected*.

Messrs. Nuciforo, Rosenberg, Ms. Spilka and Mr. Tarr moved that the bill be amended by inserting at the end thereof the following sections:-

SECTION X. Section 1 of chapter 32 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting in line 191, after the word "Authority", the following:— , Commonwealth Care Health Insurance Exchange Corporation.

SECTION X. The General Laws are hereby amended by inserting after chapter 176P the following:—

CHAPTER 176Q.

COMMONWEALTH CARE HEALTH INSURANCE EXCHANGE.

Section 1. It is declared that for the benefit of the people of the commonwealth, the increase of their commerce, welfare and prosperity and the improvement of their health and living conditions, it is essential that this and future generations of citizens be given the fullest opportunity to have and retain health care insurance at an affordable price. It is recognized that costs associated with health insurance are increasingly burdensome and that it is essential that citizens be provided with quality health insurance products at a lower cost, which are easily understandable and convenient to purchase. It is also recognized that these conditions do not exist today in the commonwealth. Accordingly, it is the purpose of this chapter and the policy of the commonwealth to provide a means to encourage the development of innovative and affordable health insurance products and encourage the purchase of those products.

Section 2. As used in this chapter the following words shall unless the context clearly requires otherwise have the following meanings: —

“Board”, board of the Commonwealth Care Health Insurance Exchange.

“Business entity”, a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“Carrier”, an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit 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.

“Commissioner”, the commissioner of the division of insurance.

“Commonwealth Care Seal of Approval”, board approval that the health benefit plan meets certain standards regarding value.

“Corporation”, the Commonwealth Care Health Insurance Exchange.

“Eligible individuals”, an individual who is a resident of the commonwealth; provided that the individual is not offered subsidized health insurance by an employer with more than 50 employees or the individual is not enrolled for coverage (i) under Part A or Part B of Title XVIII of the federal Social Security Act, (ii) a state plan under Title XIX of such act or any successor program.

“Eligible small groups,” groups, any sole proprietorship, labor union, educational, professional, civic, trade, church, not-for profit or social organization or firms, corporations, partnerships or associations actively engaged in business that on at least 50 percent of its working days during the preceding year employed at least one but not more than 50 employees.

“Exchange”, Commonwealth Care Health Insurance Exchange.

“Health benefit plans,” any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit hospital service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words “health plan” shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers’ 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 if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter l5A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

“Mandated benefits”, a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.

“Participating institution”, eligible groups that purchase health benefit plans through the Exchange.

“Sub-Exchange”, authorized by the Division of Insurance to offer all health benefit plans that the Exchange may offer, including all health benefit plans with the Commonwealth Care Seal of Approval, to eligible small employers and individuals.

“Sub-Contracted Entities”, a locally incorporated and governed organization, having had at least ten (10) years experience in the small business health insurance market, and which has served as a health insurance intermediary in the small group health insurance market under Chapter 176J.

Section 3. (a). There is hereby created a body politic and corporate and a public instrumentality to be known as the Commonwealth Care Health Insurance Exchange Corporation, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the Corporation of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the

Corporation is to implement the Commonwealth Care Health Insurance Exchange, whose purpose is to facilitate the availability, choice and adoption of private

health insurance plans to eligible individuals and groups as described in this chapter.

(b) The Corporation shall consist of a 9 member board: the commissioner of the division of health care finance and policy; the secretary for administration and finance; the executive director of the group insurance commission; the attorney general; 3 additional members appointed by the governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one shall be an employee health benefits plan specialist, and one shall be an attorney specializing in employee benefit plans; and 2 additional members appointed by the attorney general, one of whom shall be a member of a labor union, and one shall represent the interests of small businesses. No appointee may be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate two non-ex officio members for a term of three

years; two non-ex officio members for a term of four years; and one non-ex officio member for a term of five years. Thereafter, all appointments shall serve a term of five years, but a person appointed to fill a vacancy shall serve only for the unexpired term.

An appointed member of the board shall be eligible for reappointment. The governor shall appoint the chairperson and the board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee pursuant to section 6A of chapter 30.

(c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the Corporation. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.

(d) Any action of the Corporation may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the Corporation shall be subject to section 11A½ of chapter 30A; but, said section 11A½ shall not apply to any meeting of members of the Corporation serving ex officio in the exercises of their duties as officers of the commonwealth so long as no matters relating to the official business of the Corporation are discussed and decided at the meeting. The Corporation shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the Corporation shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the Corporation shall be considered to be public funds for purposes of chapter 12A. The operations of the Corporation shall be subject to chapter 268A and chapter 268B.

(e) The board shall appoint an executive director, who shall supervise the administrative affairs and general management and operations of the Corporation and who shall also serve as secretary of the Corporation, ex officio. The executive director shall receive a salary commensurate with the duties of the office, and may be removed by the board for cause. The executive director may appoint other officers and employees of the Corporation necessary to the functioning of the Corporation. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the Corporation. The executive director shall, with the approval of the board: (i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board; (ii) employ professional and clerical staff as necessary, (iii) report to the board on all operations under his control and supervision; (iv) prepare an annual budget and manage the administrative expenses of the Corporation; and (v) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

(f) Within 120 days of the effective date of this act, the executive director shall submit a plan of operation to the board and any recommended amendments to this chapter or other general laws to assure the fair, reasonable and equitable administration of the Exchange that is consistent with the provisions of this chapter and any other applicable laws and regulations, which shall provide for the effective operation of the Exchange.

(g) As of January 1, 2006 , the Corporation shall commence offering health benefit plans as set forth in section 6 of this chapter.

Section 4. The purpose of the Corporation shall be to implement the Commonwealth Care Health Insurance Exchange. The goal of the Exchange is to facilitate the purchase of health care insurance products through the Exchange at an affordable price by eligible individuals and groups. For these purposes the Corporation is authorized and empowered:

(a) To develop a plan of operation for the Exchange which shall include, but not be limited, to the following:

(1) establish procedures for operations of the Corporation directly or through one or more Sub-Contracted Entities;

(2) establish procedures for selecting an executive director;

(3) establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the Exchange;

(4) establish procedures directly or through one or more Sub-Contracted Entities for the enrollment of eligible individuals and groups;

(5) establish a plan directly or through one or more Sub-Contracted Entities for operating a health insurance service center to provide eligible individuals and groups with information on the Exchange and manage Exchange enrollment;

(6) establish and manage directly or through one or more Sub-Contracted Entities a system of collecting all premium payments made by, or on behalf of individuals obtaining health insurance coverage through the Exchange, including any premium payments made by enrollees, employees, unions or other organizations;

(7) establish a plan directly or through one or more Sub-Contracted Entities for publicizing the existence of the Exchange and Sub-Exchanges and the Exchange's and Sub-Exchanges' eligibility requirements and enrollment procedures;

(8) develop criteria for determining that certain health benefit plans shall no longer be made available through the Exchange, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans;

(9) develop a standard application form for eligible individuals and groups seeking to purchase health insurance through the Exchange, which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history and payment method.

(b) To determine each applicant's eligibility for the Exchange, MassHealth or other programs administered by the commonwealth and to direct the individual to the appropriate commonwealth agency.

(c) To seek and receive any grant funding from the Federal government, departments or agencies of the commonwealth, and private foundations.

(d) To contract with professional service firms as may be necessary in its judgment, and to fix their compensation.

(e) To contract with companies that provide third-party administrative and billing services for insurance products.

(f) To charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.

(g) To adopt by-laws for the regulation of its affairs and the conduct of its business.

(h) To adopt an official seal and alter the same at pleasure.

(i) To maintain an office at such place or places in the commonwealth as it may designate.

(j) To sue and be sued in its own name, plead and be impleaded.

(k) To establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974.

(l) To approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations.

(m) To require registration with the Exchange by any business entity in the Commonwealth having at least one employee who is ineligible to participate in an employer sponsored health benefit plan.

(n) To ensure maximum coordination with and participation by employers and employees in Health Care Plus, established by section 9C of chapter 118E.

(o) To do all things necessary to carry out the purposes of this chapter.

Section 4A. The Division of Insurance shall establish criteria, accept applications, and approve or reject licenses for certain Sub-Exchanges with which the Exchange shall contract for the provision of health benefit plans offered by the Exchange to eligible small groups and eligible individuals.

Sub-Exchanges hereunder shall be authorized to offer all health benefit plans that the Exchange may offer, including all health benefit plans with the Commonwealth Care Seal of approval. Such Sub-Exchanges must agree to provide the same or greater services as offered through the Exchange.

Section 5. (a) The Corporation may only sell health benefit plans to eligible individuals and groups.

(b) An eligible individual or small group's participation in the Exchange shall cease if coverage is cancelled pursuant to section 4 of chapter 176J.

Section 6. (a) Only health insurance plans that have been authorized by the commissioner and underwritten by a properly licensed carrier may be offered through the Exchange.

(b) Each health plan offered through the Exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.

(c) No health plan shall be offered through the Exchange that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

(d) The Corporation may only make available health benefit plans as defined in chapter 176J, which include the following categories of coverage:

(1) Preventive and primary care.

(2) Emergency services.

(3) Surgical benefits.

(4) Hospitalization benefits.

(5) Ambulatory patient benefits.

(6) Mental health services equivalent to that set forth in section 47B of chapter 175; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services. .

(7) pregnant women, infants and children services equivalent to that set forth in section 47C of chapter 175;

(8) prenatal care, childbirth and postpartum care services equivalent to that set forth in section 47F of chapter 175;

(9) cytologic screening and mammographic examination services equivalent to that set forth in section 47G of chapter 175;

(10) early intervention services services equivalent to that set forth in said section 47C of chapter 175.

(e) Except as otherwise provided in this section, a plan receiving the Commonwealth Care Seal of Approval shall not be disapproved solely on the basis that it does not include coverage for at least one mandated benefit; provided that the carrier must offer a health benefit plan that includes a prescription drug benefit option. Any health benefit plan receiving the Commonwealth Care Seal of Approval may exclude through December 31, 2008 any new mandated benefit coverage implemented after January 1, 2006 .

Section 7. Eligible small groups seeking to be a participating institution shall, as a condition of participation in the Exchange, enter in a binding agreement with the Exchange which, at a minimum, shall stipulate the following:

(1) that the employer agrees that, for the term of agreement, the employer will not offer to eligible individuals to participate in the Exchange any separate or competing group health plan offering the same, or substantially the same, benefits provided through the Exchange;

(2) that employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the Exchange and the amounts of the employer contributions, if any, to the such health plan, provided that, for the term of the agreement with the Exchange, the employer agrees not to change or amend any such criteria or contribution amounts at anytime other than during a period designated by the Exchange for participating employer health plans;

(3) that employers will participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under Federal law (USC §§104, 105, 106 and 125);

(4) that the employer agrees to make available, in a timely manner, for review by the executive director, any of the employer's documents, records or information that the Exchange reasonably determines is necessary for the executive director to: (a) verify that the employer is in compliance with applicable Federal and commonwealth laws relating to group health insurance plans, particularly those provisions of such laws relating to non-discrimination in coverage; and (b) verify the eligibility, under the terms of the health plan, of those individuals enrolled in the employer's participating health plan.

Section 8. The commonwealth, through the group insurance commission shall enter into an agreement with the Exchange whereby employees and contractors of the commonwealth who are ineligible for group insurance commission enrollment may elect to purchase a health benefit plan through the Exchange. The group insurance commission will develop a protocol for making pro-rated contributions to the chosen plan on behalf of the commonwealth.

Section 9. Commonwealth Care Seal of Approval shall be assigned to health benefit plans that the board determines (1) meets the requirements of section 6(d); (2) provides good value to consumers; and (3) is offered through the Exchange.

Section 10. (a) When an eligible individual or group is enrolled in the Exchange or Sub-Exchange by a producer licensed in the commonwealth, the health plan chosen by each eligible individual or group shall pay the producer a commission that shall be determined by the board.

(b) Any labor union, educational, professional, civic, trade, church, not-for-profit or social organization may enroll its individual eligible members, or the individual members of its member organizations, in health benefit plans offered through the Exchange, and shall receive a payment amount determined by the board from each health plan for persons who are enrolled unless the payment is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

Section 11. (a) The Exchange and Sub-Exchanges shall be authorized to apply a surcharge to individual premiums and shall be used only to pay for administrative and operational expenses of the Exchange; provided that such a surcharge shall be applied uniformly to all health benefit plans offered through the Exchange.

(b) Each carrier participating in the Exchange shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this chapter.

(c) The board may withdraw a health plan from the Exchange only after notice to the carrier.

Section 12. (a) All expenses incurred in carrying out the provisions of this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the Corporation hereunder beyond the extent to which monies shall have been provided under the provisions of this chapter.

(b) The Corporation shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer, or employee of the Corporation acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the Corporation shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the Corporation or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the Corporation except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the Corporation in the defense of any claim. Failure of such person to provide reasonable cooperation shall cause him to be jointly liable with the Corporation, to the extent that such failure prejudiced the defense of the action.

(d) The Corporation may indemnify or reimburse any person, or his personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the Corporation; provided that the defense of settlement thereof shall have been made by counsel approved by the Corporation. The Corporation may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action hereunder shall be brought more than three years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the Corporation, all rights and properties of the Corporation shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the Corporation, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 13. The Corporation shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its members, to the governor and to the state auditor, such reports

to be in a form prescribed by the members, with the written approval of said auditor. The members or said auditor may investigate the affairs of the Corporation, may severally examine the properties and records of the Corporation, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the Corporation. The Corporation shall be subject to biennial audit by the state auditor.

Section 14. No later than 3 years after the Exchange begins operation and every year thereafter, the Corporation shall conduct a study of the Exchange and the persons enrolled in the Exchange and shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on status and activities of the Corporation based on data collected in the study. The report shall also be available to the general public upon request. The study shall review:

(1) the operation and administration of the Exchange, including surveys and reports of health benefits plans available to eligible individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the Exchange and enrollees purchasing health benefit plans as defined by chapter 176J outside of the Exchange, expenses, claims statistics, complaints data, how the Exchange met its goals, and other information deemed pertinent by the Corporation; and (2) any significant observations regarding utilization and adoption of the Exchange.

Section 15. The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to affect the purposes hereof.

SECTION X. Notwithstanding any general or special law to the contrary, on June 30, 2006 , the state comptroller shall transfer $1,500,000 from the Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for the purposes of educating and increasing the awareness of uninsured residents of the commonwealth as to their options for becoming insured through the Corporation.

SECTION X. Notwithstanding any general or special law to the contrary, on June 30, 2006 , the state comptroller shall transfer $4,500,000 from the Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for administrative and operating expenses of the Corporation.

After remarks, the question on adoption of the amendment was determined by a call of the yeas and the nays at eleven minutes past five o’clock P.M., on motion of Mr. Lees, as follows, to wit (yeas 38 — nays 0) **[Yeas and Nays No. 195]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O’Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at a quarter past five o'clock P.M., the amendment was adopted.

Messrs. Morrissey, McGee and Antonioni moved that the bill be amended by striking out section 46 and inserting in place the following:—

"SECTION 46. Section 4 of Chapter 32B of the General Laws, as appearing in the 2004 Official Edition, is hereby amended in paragraph 3 by inserting, at the end thereof, the following sentence:— 'An employee, who elects to forego coverage under the employer's group health insurance plan pursuant to this section and receives services through the uncompensated care poll or Medicaid shall be considered a voluntarily uninsured employee for the purposes of Chapter 118G of the General Laws.'."
The amendment was adopted.

Mr. Augustus moved that the bill be amended at the end thereof, by adding the following new sections:—

"SECTION ___. There is hereby established MassHealth provider payment account, administered by the secretary of the executive office of health and human services. Subject to the availability of federal financial participation, funds shall be expended from this account for supplemental Medicaid payments to qualifying providers."; by adding the following new section:—_

"SECTION ___. The Comptroller shall transfer $366,000,000 from the general fund to the MassHealth provider payment account established to make supplemental Medicaid rate payments to qualifying providers."
The amendment was adopted.

Mr. Montigny, Ms. Wilkerson, Ms. Chandler, Ms. Jehlen, Ms. Creem, Ms. Fargo, Messrs. McGee, Barrios, Ms. Resor and Messrs. Antonioni and Pacheco moved that the bill be amended by adding the following new sections:—

"SECTION __. Section 9A of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in line 80, the figure '133' and inserting in place thereof the following figure:— 200.

SECTION ___. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby amended by adding the following clause:—

(j) adults 19 to 64, inclusive, whose financial eligibility as determined by the division does not exceed 100 per cent of the federal poverty level.

SECTION ___. Section 16D of said chapter 118E is hereby amended by striking out subsections (3), (4) and (6).

SECTION ___. Said chapter 118E is hereby further amended by adding the following section:—

Section 53. The division shall include within its covered services for adults all federally optional services that were included in its state plan in effect on January 1, 2002."

After remarks, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-nine minutes before six o'clock P.M., on motion of Mr. Montigny, as follows, to wit (yeas 38 — nays 0) **[Yeas and Nays No. 196]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela

Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at twenty-five minutes before six o'clock P.M., the amendment was adopted.

Mr. McGee moved that the bill be amended by striking out the following sections in their entirety:— sections 22, 23 26, and 28. The amendment was *rejected*.

Ms. Murray moved that the bill be amended by striking out section 12 and inserting in place thereof the following:—

"SECTION 12. Subsection (2) of section 9A of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out clause (c) and inserting in place thereof the following clause:—

(c) children and adolescents, from birth to 18 years, inclusive, whose financial eligibility as determined by the division exceeds 133 per cent but is not more than 300 per cent of the federal poverty level, including such children and adolescents made eligible for medical benefits under this chapter by Title XXI of the Social Security Act."; in section 29 by striking out the figure "$70,000" and inserting in place thereof the following figure:— "$100,000"; in section 31 by striking out the figure "$70,000" and inserting in place thereof the following figure:— "$100,000"; in section 38, in subsection (b), by striking out clause (ii) and inserting in place thereof the following clause:—

"(ii) the extent and duration of such coverage; the populations served; the assurance that every provider will be held harmless with respect to any rate of payment that has been established for it by the division as of the effective date of this section for services it provides pursuant to chapter 118E of the General Laws; and the requirement to maximize federal reimbursement; provided, however, that the division shall fully implement payments for covered hospital services as provided for under this section not later than the beginning of hospital fiscal year 2008; provided further, that, for each of hospital fiscal years 2006 and 2007, the division shall annually calculate rates of payment for covered hospital services under this section by adjusting the prior year's rates by an amount equal to 10 per cent of the Medicare equivalent payment rates that the division reasonably determines will be in effect as of October 1, 2007, without regard to adjustments to reflect increases in the Medicare hospital market basket index, plus an amount not less than the annual increase in the Medicare hospital market basket index in accordance with this section; provided further, that, for rates that are to be effective during hospital fiscal year 2006 pursuant to this section, called the adjusted hospital fiscal year 2006 rates, the prior year's rates shall be those rates established by the division and in effect on October 1, 2005, before the effective date of this section, called the initial hospital fiscal year 2006 rates, and the division shall further adjust the adjusted hospital fiscal year 2006 rates to account for the differences between the initial and the adjusted hospital fiscal year 2006 rates for the period from October 1, 2005 through the effective date of the implementation of the adjusted hospital fiscal year 2006 rates; and provided further, that once such systems and fee schedules are fully implemented, the division shall ensure that the rates paid for covered services under said chapter 118E shall not thereafter be less than the rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section."; by inserting, after section 59, the following 2 sections:—

"SECTION 59A. Not later than July 1, 2006, the governing committee established by section 8 of chapter 178J of the General Laws shall submit to the commissioner of insurance a proposal for effectively terminating the operation of the plan established by said section 8 of said chapter 176J. The proposal shall be subject to the approval of the commissioner and shall be fully implemented not later than 12 months after such approval.

SECTION 59B. Not later than July 1, 2006, the governing committee established by subsection (b) of section 6 of chapter 176M of the General Laws shall submit to the commissioner of insurance a proposal for effectively terminating the operation of the plan established by subsection (a) of said section 6 of said chapter 176M. The proposal shall be subject to the approval of the

commissioner and shall be fully implemented not later than 12 months after such approval.”.
The amendment was adopted.

Messrs. Tolman and Joyce moved that the bill be amended by adding, at the end thereof, the following new section:—

“SECTION XX. Notwithstanding the provisions of any general or special law to the contrary, all managed care organizations contracting or delivering behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, Title XXI-CHIP, any MassHealth expansion population served under section 115 waivers, so-called, any all youth in the care and custody of the department of social services or the department of youth services, including any specialty behavioral health managed care organization contracted to administer said behavioral health services, shall be required to obtain the approval of the commissioner of the department of mental health for all of the behavioral health benefits; including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. For purposes of this section, specialty behavioral health managed care organization shall mean a managed care organization whose primary line of business is the management of mental health and substance abuse services.”.
The amendment was adopted.

The Ways and Means amendment, as amended (Senate, No. 2276, printed as amended), was then considered, and it was adopted.

The yeas and nays having been completed at twenty-five minutes before seven o’clock P.M., the amendment was adopted.

The bill (House, No. 4479) was then ordered to a third reading.

The rules were suspended, on motion of Ms. Murray and the bill was read a third time.

The question on passing the bill to be engrossed was determined by a call of yeas and nays, at twenty-three minutes before six o’clock P.M., on motion of Ms. Murray, as follows to wit (yeas 38 — nays 0) **[Yeas and Nays No. 197]**:

YEAS.

Antonioni, Robert A.	Menard, Joan M.
Augustus, Edward M., Jr.	Montigny, Mark C.
Baddour, Steven A.	Moore, Richard T.
Barrios, Jarrett T.	Morrissey, Michael W.
Berry, Frederick E.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O’Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **38.**

NAYS — 0.

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at twenty-one minutes before six o'clock P.M., the bill was passed to be engrossed with the amendments. [For text of Senate amendments, see Senate, No. 2276, printed as amended.]
Sent to the House for concurrence in the amendments.

The Senate Bill making appropriations for fiscal year 2006 to provide for health access, affordability and accountability (Senate, No. 2265),— was read a second time.

There being no objection, and pending the question on ordering the bill to a third reading, the following amendments were considered as one and were *rejected*, to wit:

Ms. Walsh moved that the bill be amended in section 2A by inserting, after item 7002-0901, the following item:—

"7004-0097
$1,100,000 shall be expended to the town of Norwood for a one-time matching grant for the elderly population growth project".
The amendment was *rejected*.

Ms. Chandler moved that the bill be amended in section 2 by inserting the following:—

"4513-1113 .....500,000".
The amendment was *rejected*.

Messrs. O'Leary and McGee moved that the bill be amended by adding, at the end thereof, the following new section:—

"SECTION ___. Chapter 45 of the acts of 2005 is hereby amended, in section 2, in item 4512-0500, by inserting after the word 'program', the following:— 'provided further, that not less than $750,000 shall be expended for the purposes of funding the start-up costs of a pilot project administered by Forsyth Institute known as the Center for Children's Oral Health, which shall offer preventive school based oral health care to children in high need areas including but not limited to Boston, Lynn and Hyannis; provided further, that said grants shall be matched by contributions from, private entities, equal to one times the expenditures on said pilot from this line item; provided further, a report shall be filed with the joint committee on health care financing and house and senate committees on ways and means no later than December 31, 2006 on the findings of said project including but not limited to, the number of children receiving care, and the sustainability through MassHealth of said pilot."; and by striking out the figure "$1,678,150", and inserting in place thereof the following figure:— "$2,428,150".
The amendment was *rejected*.

Mr. Tolman moved that the bill be amended in section 2 by adding the following:—

"4513-1113 .....500,000".
The amendment was *rejected*.

As previously stated, the above amendments were considered as one, and were *rejected.*

There being no objection, the following amendments were considered as one and were adopted, to wit:

Ms. Resor, Ms. Fargo, Ms. Jehlen, Ms. Creem and Ms. Spilka moved that the bill be amended in section 3, subsection (1), by inserting after the words "community health centers", the following:— "clinics licensed under Chapter 111 section 51.".
The amendment was adopted.

Ms. Murray moved that the bill be amended by striking out section 3 and inserting in place thereof the following section:—

"SECTION 3. Chapter 29 of the General Laws is hereby amended by inserting, after section 2NNN, the following new section:—

Section 2OOO. There shall be established on the books of the commonwealth a Health Care Access and Investments Trust Fund which shall be administered by the secretary of health and human services with the counsel, input and recommendations of the MassHealth payment policy advisory board. The purpose of the fund shall be to maintain a world class health care system by making targeted investments to certain participating Medicaid providers and to accomplish the following:

1) invest in acute care hospitals, community health centers and physicians who participate in the MassHealth program;

2) encourage MassHealth providers to increase enrollment in the MassHealth program and lower the number of uninsured patients in the commonwealth;

3) provide incentive to MassHealth providers to deliver care and encourage the use of low-cost settings;

4) encourage hospitals to implement safe staffing models, reduce medical errors and invest in technologically advanced capital equipment; and

5) address the practice of cost-shifting to providers and consumers.

All amounts from the trust fund shall be subject to appropriation. All interest earned on the amounts in said fund shall be deposited or retained in said fund. The secretary shall seek federal financial participation for any expenditures of these funds; provided, however, that all federal reimbursements received for expenditures from this item shall be credited to the General Fund."; in section 7 by striking out the figure "$172,575,000" and inserting in place thereof the following:— "$162,575,000"; by inserting, after section 9 the following 3 sections:—

"SECTION 9A. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval, effective immediately, to eliminate enrollment caps for the programs authorized in section 9C of chapter 118E of the General Laws.

SECTION 9B. Notwithstanding any special or General Law to the contrary, in fiscal year 2006, $90,000,000 shall be made available from the Health Care Access and Investment Trust Fund to pay for an increase in Medicaid rates paid to hospitals and community health centers. An additional $16,000,000 shall be made available for an increase in rates for physicians. All rate increases shall be in accordance with provisions of that fund.

SECTION 9C. Notwithstanding any special or General Law to the contrary, in fiscal year 2007, $90,000,000 shall be made available from the Health Care Access and Investment Trust Fund to pay for an increase in Medicaid rates paid to hospitals and community health centers. An additional $16,000,000 shall be made available for an increase in rates for physicians. All rate increases shall be in accordance with provisions of that fund.".
The amendment was adopted.

Mr. Tolman moved that the bill be amended in section 3, subsection (1), by striking out the words "acute care".
The amendment was adopted.
As previously stated, the above amendments were considered as one, and were adopted.

The bill (Senate, No. 2265, amended) was ordered to a third reading.

The rules were suspended, on motion of Mr. Havern, and the bill was read a third time.

The question on passing the bill to be engrossed was determined by a call of yeas and nays, at eighteen minutes before six o'clock P.M., on motion of Mr. Lees, as follows to wit (yeas 37 — nays 0) **[Yeas and Nays No. 198]**:

YEAS.

Antonioni, Robert A.	Montigny, Mark C.
Augustus, Edward M., Jr.	Moore, Richard T.
Baddour, Steven A.	Morrissey, Michael W.
Barrios, Jarrett T.	Murray, Therese
Brewer, Stephen M.	Nuciforo, Andrea F., Jr.
Brown, Scott P.	O'Leary, Robert A.
Buoniconti, Stephen J.	Pacheco, Marc R.
Chandler, Harriette L.	Panagiotakos, Steven C.
Creem, Cynthia Stone	Resor, Pamela
Fargo, Susan C.	Rosenberg, Stanley C.
Hart, John A., Jr.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne — **37.**

Menard, Joan M.

NAYS — 0.

ABSENT OR NOT VOTING.

Berry, Frederick E. Creedon, Robert S., Jr**. — 2.**

The yeas and nays having been completed at a quarter before six o'clock P.M., the bill was passed to be engrossed with the amendments. [For text of Senate amendments, see Senate, No. 2275, printed as amended.]
Sent to the House for concurrence.

The Senate Bill further regulating public charities (Senate, No. 2267) (its title having been changed by the committee on Bills in the Third Reading),— was read a third time.

After debate, the question on passing it to be engrossed was determined by a call of the yeas and nays, at twenty-one minutes past six o'clock P.M. on motion of Ms. Walsh, as follows, to wit (yeas 33 — nays 4) **[Yeas and Nays No. 199]**:

YEAS.

Antonioni, Robert A.	Montigny, Mark C.
Augustus, Edward M., Jr.	Moore, Richard T.
Baddour, Steven A.	Morrissey, Michael W.
Barrios, Jarrett T.	Nuciforo, Andrea F., Jr.
Berry, Frederick E.	O'Leary, Robert A.
Brewer, Stephen M.	Pacheco, Marc R.
Buoniconti, Stephen J.	Panagiotakos, Steven C.
Chandler, Harriette L.	Resor, Pamela
Creem, Cynthia Stone	Rosenberg, Stanley C.
Fargo, Susan C.	Spilka, Karen E.
Havern, Robert A.	Tarr, Bruce E.
Jehlen, Patricia D.	Tisei, Richard R.
Joyce, Brian A.	Tolman, Steven A.
Knapik, Michael R.	Tucker, Susan C.
Lees, Brian P.	Walsh, Marian
McGee, Thomas M.	Wilkerson, Dianne **— 33.**
Menard, Joan M.	

NAYS .

Brown, Scott P.	Hedlund, Robert L.
Hart, John A., Jr.	Timilty, James E. **— 4.**

ANSWERED "PRESENT".

Murray, Therese **— 1.**

ABSENT OR NOT VOTING.

Creedon, Robert S., Jr. **— 1.**

The yeas and nays having been completed at twenty-four minutes past six o'clock P.M., the bill was passed to be engrossed.
Sent to the House for concurrence.

Report of a Committee.

By Ms. Murray, for the committee on Ways and Means, that the House Bill providing benefits to service members, veterans and their families (House, No. 4469, amended),— ought to pass, with an amendment, by inserting after section 2 the following section:—

"SECTION 2A. Section 19 of chapter 15A of the General Laws, as so appearing, is hereby amended by inserting after the second paragraph the following paragraph:—

Such guidelines shall provide tuition and fee waivers for veterans, as defined by section 7 of chapter 4. The commonwealth, not the institutions of public higher education, shall bear the cost of such tuition and fee waivers for veterans."; and by striking out section 12 (inserted by amendment by the House).

There being no objection, the rules were suspended, on motion of Ms. Murray, and the bill was read a second time and was amended, as recommended by the committee on Ways and Means.

The bill, as amended, was then ordered to a third reading.

Order Adopted.

On motion of Mr. Brown,—

Ordered, That when the Senate adjourns today, it adjourn to meet again tomorrow at one o'clock P.M., in a full formal session.

Adjournment in Memory of Captain Joel Cahill.

The Senator from the Norfolk, Bristol and Middlesex, Mr. Brown, and the Senator from Suffolk and Norfolk, Ms. Walsh, moved that when the Senate adjourns today, it adjourn in memory of Captain Joel Cahill, formerly of Wrentham, who died Sunday, November 6, 2005 in Ad Dwar, Iraq, when a bomb was detonated near his humvee.

Accordingly, as a mark of respect to the memory of Captain Joel Cahill, at twenty-six minutes past six o'clock P.M., on motion of Mr. Brown, the Senate adjourned to meet again tomorrow at one o'clock P.M.