UNCORRECTED PROOF OF THE JOURNAL OF THE SENATE.

JOURNAL OF THE SENATE.

Tuesday, May 18, 2010.

Met at one minute past eleven o'clock A.M. (Mr. Brewer in the Chair).

Distinguished Guests.

There being no objection, the President handed the gavel to Ms. Chandler for the purpose of an introduction. Ms. Chandler then introduced, in the rear of the Chamber, the Burncoat High School Quadrivium. They addressed the Senate by singing the National Anthem and withdrew from the Chamber. They were also guests of Senators Michael O. Moore and Brewer.

Petition.

Mr. Pacheco presented a petition (subject to Joint Rule 12) of Marc R. Pacheco and James H. Fagan for legislation to designate the recovery resource center at Taunton State Hospital as the Dr. Marie King Recovery Resource Center;
Referred, under Senate Rule 20, to the committees on Rules of the two branches, acting concurrently.

Report of a Committee.

By Mr. Montigny, for the committee on Bonding, Capital Expenditures and State Assets, that the Senate Bill authorizing the Commonwealth of Massachusetts to convey a certain parcel of land in the town of Dartmouth (Senate, No. 2198),-- **ought to pass, with an amendment substituting a new draft with the same title (Senate, No. 2443);**
Referred, under Senate Rule 27, to the committee on Ways and Means.

Committees Discharged.

Mr. Berry, for the committees on Rules of the two branches, acting concurrently, reported, asking to be discharged from further consideration
Of the Senate Order relative to authorizing the joint committee on Education to make an investigation and study of certain current Senate documents relative to personnel issues (Senate, No. 2439);
Of the Senate Order relative to authorizing the joint committee on Education to make an investigation and study of certain current Senate documents relative to Chapter 70 (Senate, No. 2440);
Of the Senate Order relative to authorizing the joint committee on Education to make an investigation and study of certain current Senate documents relative to the School Building Authority (Senate, No. 2441);
And recommending that the same severally be referred to the Senate committee on Ethics and Rules.
Under Senate Rule 36, the reports were considered forthwith and accepted.

PAPERS FROM THE HOUSE.

Petitions were severally referred, in concurrence, as follows, to wit:
Petition (accompanied by bill, House, No. 4680) of F. Jay Barrows (by vote of the town) that the town of Foxborough be

authorized to construct, maintain and operate a sewage system for said town;
To the committee on Environment, Natural Resources and Agriculture.
Petition (accompanied by bill, House, No. 4678) of Allen J. McCarthy and Thomas P. Kennedy (by vote of the town) for legislation to further regulate tax titles in the town of East Bridgewater; and
Petition (accompanied by bill, House, No. 4679) of Robert L. Rice, Jr. and Jennifer L. Flanagan (with the approval of the mayor and city council) that the city of Gardner be authorized to convey certain land to the Greater Gardner Industrial Foundation;
Severally to the committee on Municipalities and Regional Government.

A Bill establishing the Essex County Commission on the Status of Women (House, No. 3410,- on petition), -- **was read and, under Senate Rule 27, referred to the committee on Ways and Means.**

Bills
Relative to precautions at railroad crossings (House, No. 3206,-- on House, Nos. 3202 and 3206);
Designating a certain bike path in the town of Millbury as the Honorable Richard Dwinell Memorial Blackstone Valley bike path (House, No. 3218,-- on House, No. 3218 and 3219);
Relative to the transportation of swimming pools (House, No. 4025,-- on petition);
Relative to National Heritage Commissions and Corridors in the Commonwealth (House, No. 4492,-- on House, No. 3142);
Were severally read and, under Senate Rule 26, referred to the committee on Ethics and Rules.

Bills
Authorizing the city of Methuen to repay the borrowing of certain monies for a period of up to 20 years (House, No. 4404,- on petition) [Local approval received] ; and
Establishing a road maintenance revolving account in the town of Brewster (House, No. 4495,- on petition) [Local approval received];
Were read and, under Senate Rule 26, placed in the Orders of the Day for the next session.
The following House Order (approved by the committees on Rules of the two branches, acting concurrently) was considered forthwith, as follows, to wit:
Ordered, that the committee on Municipalities and Regional Government be authorized to travel throughout the Commonwealth between Monday, May 3, 2010 and Thursday, June 10, 2010 for the purpose of holding hearings on the subject of regionalization.
Under Senate Rule 26, referred to the committee on Senate Ethics and Rules.

There being no objection, at two minutes past eleven o'clock A.M., the Chair (Mr. Brewer) declared a recess subject to the call of the Chair; and, at two minutes before twelve o'clock noon, the Senate reassembled, the President in the Chair.

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

At one minute before twelve o'clock noon, Mr. Downing doubted the presence of a quorum. The President, having determined that a quorum was not in attendance, then directed the Sergeant-at-Arms to secure the presence of a quorum.
Subsequently, at one minute past twelve o'clock noon, a quorum was declared present.

Resolutions.

The following resolutions (having been filed with the Clerk) were severally considered forthwith and adopted, as follows:-
Resolutions (filed by Mr. Baddour) "congratulating Nicholas John Costello on receiving a 2010 Essex Heritage Hero Award";
Resolutions (filed by Mr. Baddour) "congratulating Byron John Matthews on receiving a 2010 Essex Heritage Hero Award";
Resolutions (filed by Mr. Baddour) "congratulating Maria Miles on receiving a 2010 Essex Heritage Hero Award"; and
Resolutions (filed by Mr. Knapik) "honoring Maria B. Dwight."

PAPERS FROM THE HOUSE

Emergency Preamble Adopted.

An engrossed Bill establishing a sick leave bank for Stephen R. Fratalia, an employee of the Trial Court (see House, No. 4576), having been certified by the Senate Clerk to be rightly and truly prepared for final passage and containing an emergency preamble,-- **was laid before the Senate; and, a separate vote being taken in accordance with the requirements of Article LXVII of the Amendments to the Constitution, the preamble was adopted in concurrence, by a vote of 4 to 0.**
The bill was signed by the President and sent to the House for enactment.
Engrossed Bill.

An engrossed Bill providing for recall elections in the town of Boxford (see House, No. 4381, amended) (which originated in the House), having been certified by the Senate Clerk to be rightly and truly prepared for final passage, was passed to be enacted and signed by the President and laid before the Governor for his approbation.

Report of Committees.

By Mr. Berry, for the committees on Rules of the two branches, acting concurrently, that Joint Rule 12 be suspended on the Senate petition of Susan C. Fargo, Thomas P. Conroy and Cory Atkins for legislation relative to the improvement of Route 2 Crosby's Corner interchange in the town of Lincoln and Concord.
The rules were suspended, on motion of Mr. Petruccelli, and the report was considered forthwith. Joint Rule 12 was suspended; and the petition (accompanied by bill) was referred to the committee on Transportation.
Sent to the House for concurrence.

PAPER FROM THE HOUSE.

A petition (accompanied by bill, House, No. 4685) of John P. Fresolo for legislation to further regulate vehicles for hire,- **was referred, in concurrence, under suspension of Joint Rule 12, to the committee on Transportation.**

Orders of the Day.

The Orders of the Day were considered, as follows:
The House Order relative to extending until Tuesday, May 18, 2010, the time within which joint committees and the committees on Rules of the two branches, acting concurrently are authorized to make reports on all matters referred to them,-- **was taken up out of order and considered forthwith.**
The pending motion, previously moved by Mr. Tisei, to lay the order on the table was considered; and it was negative. After remarks, and pending the call of the yeas and nays, previously moved by Mr. Tisei, on the question on adoption of the order, Mr. Tisei again moved that the order be laid on the table; and, in accordance with the provisions of Senate Rule 24, the consideration of the motion to lay on the table was postponed, without question, until the next session.

The Committee Bill to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses (Senate, No. 2437),-- **was read a second time.**
After remarks, and pending the question on ordering the committee bill to a third reading, Mr. Petruccelli moved to amend the committee bill by inserting after section 2, the following 2 sections:-
"SECTION 2A. Section 2 of chapter 32A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following subsection:-
(i) "Wellness program", a program designed to measure and improve individual health by identifying risk factors, principally through diagnostic testing and establishing plans to meet specific health goals which include appropriate preventive measures. Risk factors may include but shall not be limited to demographics, family history, behaviors and measured biometrics.
SECTION 2B. Said chapter 32A is hereby further amended by adding the following section:-
Section 25. The commission shall, subject to appropriation, negotiate with and purchase, on such terms as it deems to be in the best interest of the commonwealth and its employees, from 1 or more entities that can manage a wellness program covering persons in the service of the commonwealth and their dependents, and shall execute all agreements or contracts pertaining to said program. The commission may negotiate a contract for such term not exceeding 5 years as it may, in its discretion, deem to be the most advantageous to the commonwealth; provided, however that said program must be able to evaluate individual and aggregate data, give employees access to their individual information confidentially and allow the commission to receive collective reports summarizing baseline and ongoing data regarding the behavior and well being of enrollees. The commission may reduce premiums or co-payments or offer other incentives to encourage enrollees to comply with the wellness program goals.
Beginning 1 year after the end of the fiscal year in which the commission, has implemented the wellness program, the commission shall submit an annual report to the governor, the secretary of health and human services, the secretary of administration and finance, the chairs of the joint committees on health care financing, the house and senate committees on ways and means, the speaker of the house of representatives and the senate president. The report shall include the collective results, including but not limited to, the level of participation among employees, incentives provided for participation, the number and type of screenings and diagnostic tests conducted, the instance of undiagnosed risks defined as out of range diagnostic tests and number of employees seeking and receiving preventative treatment. The commission shall use this information in the negotiating and purchasing, on such terms as it deems in the best interest of the commonwealth and its employees, from 1 or more insurance companies, savings banks or non-profit hospital or medical service corporations, a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits covering persons in the service of the commonwealth and their dependents.
Beginning 1 year after the end of the fiscal year in which the commission, has implemented the wellness program, the commission shall annually submit a report to the governor, secretary of administration and finance, the chairs of the joint committees on health care financing, the house and senate committees on ways and means, the speaker of the house of representatives and the senate president on the savings that have been achieved in procuring such insurance policies since implementing the wellness program."
After remarks, the amendment was adopted.
Ms. Fargo moved to amend the committee bill by striking out section 50 and inserting in place thereof the following section:-
"SECTION 50. The department of public health shall promulgate regulations under section 25P of chapter 111 of the General Laws by December 31, 2010 requiring the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the "Standard Quality Measure

Set."
The department of public health shall convene a statewide advisory committee which shall recommend to the department by November 1, 2010 the Standard Quality Measure Set. The statewide advisory committee shall consist of the commissioner of health care finance and policy or the commissioner's designee, who shall serve as the chair; and up to 8 members, including the executive director of the group insurance commission and the Medicaid director, or the directors designees; and up to 6 representatives of organizations to be appointed by the governor including at least 1 representative from an acute care hospital or hospital association, 1 representative from a provider group or medical association or provider association, 1 representative from a medical group, 1 representative from a private health plan or health plan association, 1 representative from an employer association and 1 representative from a health care consumer group.
In developing its recommendation of the Standard Quality Measure Set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall annually recommend to the department of public health any updates to the Standard Quality Measure Set by November 1. For its recommendation beginning in 2011, the committee may solicit for consideration and recommend other nationally recognized quality measures not yet developed or in use as of November 1, 2010, including recommendations from medical or provider specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the Standard Quality Measure Set shall consist of the following quality measures:
(i) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention;
(ii) the Hospital Consumer Assessment of Healthcare Providers and Systems survey;
(iii) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and
(iv) the Ambulatory Care Experiences Survey."
The amendment was adopted.
Ms. Fargo and Ms. Flanagan moved to amend the committee bill in section 9, by inserting, in line 123, after the word "contracts" the following words:- ", type of provider licensure"; and in section 32, by inserting, in line 540, after the word "credentialing" the following words:- "of providers, including any health care provider type licensed under chapter 112 of the General Laws that provide identical services".
The amendment was adopted.
Mr. Tolman moved to amend the committee bill by inserting the following section at the end of the bill:-
"The division and the executive office of health and human services shall establish a new rate methodology to cover the cost of care provided by any facility licensed by the department of public health as a chronic disease hospital providing services solely to children and adolescents, as follows: (1) the rate of reimbursement for any such facility shall be developed collaboratively through an agreement among the office of Medicaid, the division of healthcare finance and policy and any such facility; (2) the reimbursement rate for any such facility shall incorporate the following components: (a) utilization of the reimbursement methodology used by the division and the executive office of health and human services to determine payments for Medicaid disproportionate share pediatric hospitals in effect in 2007 utilizing the most recently filed 403 cost report with the division and the payments received from Medicaid eligible patients for the base period; (b) a per diem rate for inpatient and a payment on account factor for outpatient shall be established which reimburses the full unrecovered cost, including capital; and (c) the rates shall be inflated over the base period by the applicable Medicare market basket inflation factors; and (3) notwithstanding any general or special law to the contrary, in no event will the rates of payment be lower than the rates in effect for such facility in the prior fiscal year".
The amendment was rejected.
Mr. Tolman moved to amend the committee bill by inserting after section 54, the following section:-
"Section 54A. Notwithstanding any special or general law to the contrary, in implementing this act, the executive office of health and human services, the department of public health, the division of health care finance and policy, the division of insurance, the group insurance commission and any other relevant governmental entities or commissions may consider the special needs of children and of pediatric patients. In developing or utilizing data standards, quality measurement systems, wellness initiatives or making comparisons of costs and prices, policymakers shall consider the special needs of children and of pediatric patients and may require that comparative data and reports segregate pediatric patients and providers from adult patients and providers."
The amendment was adopted.
Mr. Tolman moved to amend the committee bill by striking section 23(e) and inserting in place the following:-
"(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; the availability of pediatric specialty providers within the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network."; and by striking out section 24(e) and inserting in place the following:-
"(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; the availability of pediatric specialty providers within the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network."
The amendment was rejected.

Ms. Jehlen and Mr. Richard T. Moore moved to amend the committee bill by inserting after section 4 the following section:-
“SECTION 4A. Chapter 111 of the General Laws is hereby amended by adding the following section: -
Section 222. There shall be, within the department a commission on falls preventions. The commission shall consist of the commissioner of public health or the commissioner’s designee, who shall chair the commission; the secretary of elder affairs or the secretary’s designee; the director of MassHealth or the director’s designee; and 8 members to be appointed by the governor, 1 of whom shall be a member of the Home Care Alliance of Massachusetts, 1 of whom shall be a member of the American Association of Retired Persons, 1 of whom shall be a member of the Massachusetts Senior Care Association, 1 of whom shall be a member of the Massachusetts Councils on Aging, 1 of whom shall be a member of the Massachusetts Medical Society 1 of whom shall be a member of the Massachusetts Assisted Living Facilities Association , 1 of whom shall be a member of Mass Home Care, and 1 of whom shall be a member of the Massachusetts Pharmacists Association.
The commission on falls prevention shall make an investigation and comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The commission shall monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls. The commission shall:
(1) consider strategies to improve data collection and analysis to identify fall risk, health care cost data and protective factors;
(2) consider strategies to improve the identification of older adults who have a high risk of falling;
(3) consider strategies to maximize the dissemination of proven, effective fall prevention interventions and identify barriers to those interventions;
(4) assess the risk and measure the incidence of falls occurring in various settings;
(5) identify evidence-based strategies used by long-term care providers to reduce the rate of falls among older adults and reduce the rate of hospitalizations related to such falls;
(6) identify evidence-based community programs designed to prevent falls among older adults;
(7) review falls prevention initiatives for community-based settings; and
(8) examine the components and key elements of the above falls prevention initiatives, consider their applicability in the commonwealth and develop strategies for pilot testing, implementation and evaluation.
The commission on falls prevention shall submit to the secretary of health and human services and the joint committee on health care financing, not later than September 22, an annual report that includes findings from the commission’s review along with recommendations and any suggested legislation to implement those recommendations. The report shall include recommendations for:
(1) intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies;
(2) strategies that promote collaboration between the medical community, including physicians, long-term care providers and pharmacist to reduce the rate of falls among their patients;
(3) programs that are targeted to fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations;
(4) programs that encourage partnerships to prevent falls among older adults and prevent or reduce injuries when falls occur; and
(5) programs to encourage long-term care providers in the commonwealth to implement falls prevention strategies which use specific interventions to help all patients avoid the risks for falling in an effort to reduce hospitalizations and prolong a high quality of life.”
The amendment was adopted.
Messrs. Tisei, Tarr, Knapik and Hedlund moved to amend the committee bill by inserting the following section: -
“SECTION X. Section 1 of chapter 111L, as added by section 12 of chapter 58 of the acts of 2006, is hereby amended by inserting at the end of the definition of the term ‘Creditable coverage’ the following words:- Minimum creditable coverage, as defined by the board under the authority granted herein, shall not require coverage for prescription drugs.
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at twenty-four minutes past two o’clock P.M., on motion of Mr. Tarr, as follows, to wit (4 yeas – 31 nays) [Yeas and Nays No. 239]:
INSERT ROLL CALL 239
The yeas and nays having been completed at a half past two o’clock P.M., the amendment was rejected.
Messrs. Buoniconti and Hart moved to amend the committee bill in section 34 by striking out in lines 566-569 the following clause:-
“(iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval.”
The amendment was rejected.
Messrs. Morrissey and Kennedy moved to amend the committee bill by adding a new section:--
“SECTION 31. Chapter 118G of the General Laws is hereby amended by inserting after section 15 the following section:-
Section 15A. (a) No contract for payment for hospital, physician group practice, or imaging services between a provider and a carrier as defined by chapter 176O for medical, diagnostic or therapeutic services shall take effect until approved by the division of health care finance and policy. The contract must be submitted by the provider to the division for review at least 30 days before the proposed effective date of the contract. The division shall review such contracts to determine whether provider payments under the contract exceed applicable limits, as defined by regulations promulgated by the division.
Contracts under (2.5% US City CPI)

(b) Any contract under which payments, adjusted for volume and patient acuity, would increase by a percentage lower than the twelve month change of the US city average Consumer Price Index for Medical Care Services as of December 31 of the preceding year shall be approved.
Contracts over 5.12% (Boston CPI)
(c) Any contract under which payments, adjusted for volume and patient acuity, would increase by a percentage greater than the twelve month change of the Consumer Price Index for Medical Care Services for the Boston area as of December 31 of the preceding year shall be presumptively disapproved. Within 30 days, the division shall schedule a public hearing on any contract that is presumptively disapproved, and following the hearing, the division may approve, disapprove, or approve in part such contracts. In considering such contracts, the division shall take into consideration the public payer mix of the provider, the relative level of proposed rates compared to similarly situated providers, the historical provider rate increases, the financial performance of the provider, and any other facts that the division may consider according to regulations promulgated under this Section.
This Section shall also apply to any contracts that have rate increases that have been disapproved by the division under section (f) of this Section. In such instance, rates may not increase beyond the prior year's existing rate.
Contracts over 2.5% under 5.12%
(d) Any contract under which payments, adjusted for volume and patient acuity, would increase by a percentage greater than the twelve month change of the US city average Consumer Price Index for Medical Care Services as of December 31 of the preceding year but by a percentage lower than the twelve month change of the Consumer Price Index for Medical Care Services for the Boston area as of December 31 of the preceding year may be approved by the division, provided that the Division may conduct a review prior to such approval. In conducting its review the division may conduct a public hearing. Following its review, the division may approve, disapprove, or approve in part such contracts. In considering such contracts, the division shall take into consideration the public payer mix of the provider, the relative level of proposed rates compared to similarly situated providers, the historical provider rate increases, and the financial performance of the provider.
The division, in consultation with the division of insurance, shall adopt regulations in accordance with chapter 30A to specify the criteria for contract review, and any other considerations consistent with implementation of this Section by the division.
(e) Except as specifically provided otherwise by the division, information submitted to the division under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.
(f) This section shall also apply to any contract in effect before April 1, 2010, for services provided on or after April 1, 2010. The parties shall be afforded 30 days to renegotiate any affected terms of these contracts.
(g) Providers may not shift costs to other health care payers as a result of the requirements in this section. The division may adopt regulations to specify monitoring activities and enforcement provisions, including financial penalties, for violation of this section."
After debate, the amendment was rejected.
Messrs. Petruccelli, Hart, Downing and Buoniconti moved to amend the committee bill in section 38, by inserting after the word "program", in line 721, the following words:- "or a wellness program as adopted by health carriers so long as the program meets requirements set by the commissioner of insurance,".
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at a quarter before three o'clock P.M., on motion of Mr. Tarr, as follows, to wit (8 yeas – 27 nays) [Yeas and Nays No. 240]:
INSERT ROLL CALL 240
The yeas and nays having been completed at eleven minutes before three o'clock P.M., the amendment was rejected.
Mr. Morrissey moved that the committee bill be amended by striking out section 54 and replacing it with the following new language:-
"Notwithstanding any general or special law to the contrary, there shall be a special commission to study the impact of reducing the number of health benefit plans that a health care payor may maintain and offer to individuals and employers. The commission shall include the commissioner of the division of insurance, who shall serve as chair, the executive director of the connector, a representative of the Massachusetts Hospital Association, the Massachusetts Medicaid Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a MassHealth contracted managed care organization, a representative from Associated Industries of Massachusetts, a representative from a heath care consumer group. In conducting its analysis, the commission shall examine the following (i) the administrative costs associated with pricing paying claims and submitting claims for multiple health benefit plans on health care payors and providers; (ii) the costs associated with reducing the number of health benefits plans on consumer and employer choice; (iii) the impact of limiting the number of health benefit plans on competition between and among insurance payors, including but not limited to tiered products, limited network products, and products with a range of cost sharing options; and (iv) the potential for disruption to the market resulting from closing a health care payor's existing health benefit plans.
The special commission shall convene not later than October 1, 2010 and shall submit a report to the clerks of the house and senate no later than December 31, 2010."
After remarks, the amendment was adopted.
Messrs. Tisei, Tarr, Knapik and Hedlund moved to amend the committee bill by inserting at the end thereof the following: -
"Section X. Chapter 176Q, as inserted by chapter 58 of the acts of 2006, is hereby amended by inserting at the end thereof the following new section: -
Section 17. Nothing in this chapter shall infer the legal right of the connector to advertise its services as a broker of insurance to

businesses through the business express program."
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at eight minutes past three o'clock P.M., on motion of Mr. Tarr, as follows, to wit (4 yeas – 31 nays) [Yeas and Nays No. 241]:
INSERT ROLL CALL 241
The yeas and nays having been completed at thirteen minutes past three o'clock P.M., the amendment was rejected.
Mr. Timilty moved to amend the committee bill in section 35, line 639, by striking word:- "not".
After remarks, the amendment was adopted.
Ms. Jehlen and Mr. Montigny moved that the committee bill be amended by inserting at the end thereof the following new section:-
"SECTION XX. Section 13A of chapter 90 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by striking the seventh paragraph in line 23 and inserting in place thereof the following:--
Any person who operates a motor vehicle without a safety belt, and any person sixteen years of age or over who rides as a passenger in a motor vehicle without wearing a safety belt in violation of this section, shall be subject to a fine of fifty dollars. Any operator of a motor vehicle shall be subject to an additional fine of fifty dollars for each person under the age of sixteen and no younger than twelve who is a passenger in said motor vehicle and not wearing a safety belt. The provisions of this section shall be enforced by law enforcement agencies when an operator of a motor vehicle or passenger who rides in the motor vehicle is not wearing a safety belt in violation of motor vehicle laws. Safety belt violations will not result in surcharges on motor vehicle insurance premiums and a police officer may not search or inspect a motor vehicle, its contents, the driver, or a passenger solely because of a violation of this section."
Mr. Richard T. Moore rose to a point of order, which, being stated, was that the amendment was beyond the scope of the legislation.
The President ruled that the point of order was well taken and the amendment was laid aside.

Mr. Timilty moved to amend committee bill in section 53, line 1044, after the words "health care consumer group", by inserting the following words:- "; and a representative of an association of health care providers licensed under chapter 112 who are not medical doctors (M.D.)"
After remarks, the amendment was adopted.
Ms. Creem moved to amend the committee bill by inserting in line 98, after the word "report", the following language: "and place on its website"; and by inserting the following section at the end of the bill:-
"SECTION XX. Notwithstanding any general or special law to the contrary, the Division of Insurance, in consultation with the Attorney General's Office, shall conduct a study to ensure that the carrier reporting deadlines included in Chapter 176J § 6(b) and Chapter 176J § 6(c) are of the appropriate duration to enable carriers to collect sufficient information with which to ensure the accuracy of proposed plan changes. If it is determined that a reporting date of 90 days prior to the effective date of plan changes is inappropriate, the study shall determine the appropriate amount time for carriers to report plan changes to the Division of Insurance and the Attorney General and shall make such recommendation to the Legislature. Said study shall be completed by July 31, 2011 and filed with the clerk of the legislature, the Senate and House Chairs of the Joint Committee on Health Care Financing, the chair of the Senate Ways and Means Committee and the chair of the House Ways and Means Committee."
After remarks, the question on adoption of the amendment was determined by a call of the yeas and nays, at twenty-one minutes past three o'clock P.M., on motion of Ms. Creem, as follows, to wit (36 yeas – 0 nays) [Yeas and Nays No. 242]:
INSERT ROLL CALL 242
The yeas and nays having been completed at twenty-five minutes past three o'clock P.M., the amendment was adopted.
Ms. Candaras moved to amend the committee bill in line 1041, by inserting after the words "Blue Cross and Blue Shield of Massachusetts;" the following:-
"a representative of Health New England;".
The amendment was rejected.
Mr. Pacheco moved to amend the committee bill in section 23, line 397, by inserting the following sentence at the end thereof:- "Select or tiered networks shall not discriminate against lowest cost providers."; and in section 24, line 437, by inserting the following sentence at the end thereof:- "Select or tiered networks shall not discriminate against lowest cost providers."
The amendment was rejected.
Mr. Richard T. Moore moved to amend the committee bill by inserting after section 1 the following 2 sections:-
"SECTION 1A. Section 16K of Chapter 6A of the General Laws is hereby amended by striking out subsections (a) through (c), as so appearing, and inserting in place thereof the following 3 subsections:-
Section 16K. (a) There shall be established a health care quality and cost council, 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. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to support the long term sustainability of health care reform in the commonwealth by developing recommendations for containing health care costs, while facilitating access to information on health care quality improvement efforts. The council shall disseminate health care quality and cost data to consumers, health care providers and insurers via a consumer health information website pursuant to subsection (e) and (g); establish cost containment goals pursuant to subsection (h); and coordinate ongoing quality improvement initiatives pursuant to subsection (i).
(b) The council shall consist of 18 members and shall be comprised of: (1) 9 ex-officio members, including the secretary of health and human services, the secretary of administration and finance, the state auditor, the inspector general, the attorney

general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health, and the executive director of the group insurance commission, or their designees; and (2) 9 representatives of nongovernmental organizations to be appointed by the governor, including 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be a organization representing the interests of small businesses, and 1 of whom shall be a organization representing the interests of large businesses. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall vote annually to select a chair and an executive committee, which shall consist of 4 council members and the chair. The executive committee shall meet as required to fulfill the mission of the council. Members of the council shall be appointed for terms of 3 years and shall serve until the term is completed or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. All council members shall be subject to chapter 268A; provided, however, that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided further that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall be in compliance with chapter 30A. The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services. The executive office of health and human services may provide staff and administrative support as requested by the council; provided, however, that all work completed by the executive office of health and human services shall be subject to approval by the council .

The council shall appoint an executive director to oversee the operation and maintenance of the website, ensure compliance with the requirements of this section, and coordinate work completed by the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it deems necessary.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

SECTION 1B. Said section 16K of said chapter 6A is further amended by striking out subsections (h) and (i), as so appearing, and inserting in place thereof the following 2 subsections:-

(h) The council, in consultation with its advisory committee, shall develop annual health care cost containment goals. The goals shall be designed to promote affordable, high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities. In establishing cost containment goals, the council shall utilize claims data collected from carriers pursuant to this section, and information gathered as part of the division of health care finance and policy's public hearings on health care costs pursuant to section 6 ½ of chapter 118G. For each goal, the council shall identify: the parties that will be impacted; the agencies, departments, boards or councils of the commonwealth responsible for overseeing and implementing the goal; the steps needed to achieve the goal; the projected costs associated with implementing the goal; and the potential cost savings, both short and long-term, attributable to the goal. The council may recommend legislation or regulatory changes to achieve these goals. The council shall publish a report on the progress towards achieving the costs containment goals.

(i) The council, in consultation with its advisory committee, shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care organizations. The council shall pay specific attention to programs designed to: improve patient safety in all settings of care; reduce preventable hospital readmissions; prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and reduce variations in care. The council shall compile information on programs conducted by state agencies and public and private health care organizations and make such information available on the council's consumer health information website. The council may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives."

The amendment was adopted.

Mr. Richard T. Moore moved to amend the committee bill by inserting after section __, the following new sections: -

"SECTION X. Paragraph (n) of section 5 of chapter 614 of the acts of 1968 is hereby amended by striking out the words 'its administrative' and inserting in place thereof the following words:- fees, administrative.

SECTION X. Said section 5 of said chapter 614 is hereby further amended by inserting after paragraph (n) the following paragraph:-

(n1/2) to fund the capital reserves authorized under paragraph (g) of section 10 and to fund and administer loans and grant programs for community hospitals and community health centers;

SECTION X. Section 10 of said chapter 614 is hereby further amended by adding the following paragraph:-

(g) (i) For the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health and meeting the definition of a community health center under 114.6 CMR 13.00 as either a community health center or a hospital licensed health center, the authority may create and establish special funds to be known as Community Hospital and Community Health Center Capital Reserve Funds and, to the extent so created, shall pay into each such fund any

monies appropriated and made available by the commonwealth for the purposes of such fund, any proceeds from the sale of notes or bonds to the extent provided in the resolution, trust agreement or indenture of the authority authorizing issuance thereof, any other monies or funds of the authority that the authority determines to deposit in the fund and any other monies which may be available to the authority only for the purpose of such fund from any other source or sources. All monies held in the fund, except as hereinafter provided, shall be used solely for the payment of the principal of bonds of the authority which are secured by any such fund as the same mature, which herein shall include becoming payable by sinking fund installment, the purchase of such bonds, the payment of interest on such bonds, or the payment of any redemption premium required to be paid when such bonds are redeemed prior to maturity; provided, however, that, monies in a Community Hospital and Community Health Center Capital Reserve Fund shall not be withdrawn therefrom at any time in such amount as would reduce the amount of the fund to less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on outstanding bonds which are secured by the fund, except for the purpose of paying the principal of and interest on such bonds maturing and becoming due or for the retirement of such bonds in accordance with the terms of a contract between the authority and its bondholders and for the payment of which other monies pledged to secure such bonds are not available. Any income or interest earned by, or increment to, a Community Hospital and Community Health Center Capital Reserve Fund due to the investment thereof shall be used by the authority for the purposes of the fund.

(ii) The authority shall not issue bonds which are secured by a Community Hospital and Community Health Center Capital Reserve Fund at any time if the maximum amount of principal and interest maturing or becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by a fund will exceed the amount of such Community Hospital and Community Health Center Capital Reserve Fund at the time of issuance unless the Authority, at the time of issuance of such bonds, shall deposit in such Fund from the proceeds of the bonds so to be issued, or otherwise, an amount which, together with the amount then in the fund, will be not less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by any such fund.

(iii) To assure the continued operation and solvency of the authority for the carrying out of the public purposes of this act, provision is made in subparagraph (i) for the accumulation in a Community Hospital and Community Health Center Capital Reserve Fund of an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on all outstanding bonds which are secured by any such fund. In order to further assure the maintenance of a Community Hospital and Community Health Center Capital Reserve Fund, there shall be appropriated annually and paid to the authority for deposit in the fund such sum, if any, as shall be certified by the executive director of the authority to the governor as necessary to restore the fund to an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on the outstanding bonds which are secured by any such fund. The executive director of the authority shall annually, on or before December 1, make and deliver to the governor a certificate stating the amount, if any, required to restore a Community Hospital and Community Health Center Capital Reserve Fund to the amount aforesaid and the amount so stated, if any, shall be appropriated and paid to the authority during the then current fiscal year of the commonwealth.

(iv) For the purposes of this paragraph, in computing the amount of a Community Hospital and Community Health Center Capital Reserve Fund, securities in which all or a portion of the fund are invested shall be valued at par or, if purchased at less than par, at their cost to the authority unless otherwise provided in the resolution, trust agreement or indenture authorizing the issuance of bonds secured by the fund.

(v) For the purposes of this paragraph, the amount of a letter of credit, insurance contract, surety bond or similar financial undertaking available to be drawn upon and applied to obligations to which money in the Community Hospital and Community Health Center Capital Reserve Fund may be applied shall be counted as money in the fund. For the purposes of this paragraph, in calculating the maximum amount of interest due in the future on variable rate bonds or bonds with respect to which the interest rate is not at the time of calculation determinable, the interest rate shall be calculated at the maximum interest rate on such bonds or such lesser interest rate as shall be certified by the authority as an appropriate proxy for such variable or nondeterminable interest rate.

(vi) Bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund shall be issued by the authority solely for the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health.

(vii) Notwithstanding any provision of this act to the contrary, no loan shall be made by the authority to a nonprofit community hospital or nonprofit community health center from the proceeds of bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund established under this paragraph unless: (a) the project to be financed by the loan has been approved by the secretary of health and human services; and (b) the loan and the issuance and terms of the related bonds have been approved by the secretary of administration and finance. In connection with any loan to a nonprofit community hospital or nonprofit community health center pursuant to this paragraph, the secretary of health and human services and the secretary of administration and finance may enter into an agreement with the authority and the nonprofit community hospital or nonprofit community health center to: (a) require that the nonprofit community hospital or nonprofit community health center provide financial statements or other information relevant to the financial condition of the nonprofit community hospital or nonprofit community health center and its compliance with the terms of the loan; (b) require that the nonprofit community hospital or nonprofit community health center reimburse the commonwealth for any amounts the commonwealth transfers to the fund under subparagraph (iii) to replenish the fund as a result of a loan payment default by the nonprofit community hospital or nonprofit community health center; and (c) require compliance by the nonprofit community hospital or nonprofit community health center or the authority with any other terms and conditions that the secretary of health and human services and the secretary of

administration and finance considers appropriate in connection with the loan.
(viii) When the authority notifies the secretary of administration and finance in writing that an institution eligible to use the authority under this paragraph is in default as to the payment of principal or interest on any bonds issued by the authority on behalf of that institution or that the authority has reasonable grounds to believe that the institution will not be able to make a full payment when that payment is due, the secretary of administration and finance shall direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the institution until the amount of the principal or interest due or anticipated to be due has been paid to the authority or the trustee for the bondholders, or until the authority notifies the secretary of administration and finance that satisfactory arrangements have been made for the payment of the principal and interest. Funds subject to withholding under this subparagraph shall include, but not be limited to, federal and state grants, contracts, allocations and appropriations.
(ix) If the authority further notifies the secretary of administration and finance in writing that no other arrangements are satisfactory, the secretary shall direct the comptroller to make available to the authority without further appropriation any funds withheld from the institution under subparagraph (viii). The authority shall apply the funds to the costs incurred by the institution, including payments required to be made to the authority or trustee for any bondholders of debt service on any bonds issued by the authority for the institution or payments to replenish the Community Hospital and Community Health Center Capital Reserve Fund or required by the terms of any other law or contract to be paid to the holders or owners of bonds issued on behalf of the institution upon failure or default, or upon reasonable expectation of failure or default, of the institution to pay the principal or interest on its bonds when due.
(x) Concurrent with any notice from the authority to the secretary of administration and finance under this paragraph, the authority may notify any other agency, department or authority of state government that exercises regulatory, supervisory or statutory control over the operations of the institution. Upon notification, the agency, department or authority shall immediately undertake reviews to determine what action, if any, that agency, department or authority should undertake to assist in the payment by the institution of the money due or the steps that the agencies of the commonwealth, other than the comptroller or the authority, should take to assure the continued prudent operation of the institution or provision of services to the people served by the institution.
(xi) Notwithstanding any general or special law to the contrary, in the event that a nonprofit community hospital or nonprofit community health center fails to reimburse the commonwealth for any transfers made by the commonwealth to the authority to replenish the Community Hospital and Community Health Center Capital Reserve Fund in accordance with subparagraph (iii) within 6 months after any such transfer and as otherwise provided in accordance with the terms of the agreement among the nonprofit community hospital or nonprofit community health center, the authority and the commonwealth authorized under subparagraph (vii), the secretary of administration and finance may, in his sole discretion, direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the nonprofit community hospital or nonprofit community health center to cover all or a portion of the amount the nonprofit community hospital or nonprofit community health center has failed to pay to the commonwealth to reimburse the commonwealth for any such transfers. All contracts issued by the group insurance commission, the commonwealth health insurance connector authority and MassHealth to a third party for the purposes of providing health care insurance paid for by the commonwealth shall provide that, at the direction of the secretary of administration and finance, the third party shall withhold payments to a nonprofit community hospital or nonprofit community health center which fails to reimburse the commonwealth in accordance with the agreement authorized under subparagraph (vii) and shall transfer the withheld amount to the commonwealth. Any such withheld amounts shall be considered to have been paid to the nonprofit community hospital or nonprofit community health center for all other purposes of law and the nonprofit community hospital or nonprofit community health center shall be considered to have reimbursed the commonwealth for all or a portion of any such transfers to the Community Hospital and Community Health Center Capital Reserve Fund for purposes of the agreement authorized under said subparagraph (vii).
(xii) For the purposes of this paragraph, a community hospital or community health center shall not include a hospital where the ratio of the number of physician residents-in-training to the number of inpatient beds exceeds 0.25.
SECTION X. Section 12 of said chapter 614 is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- Except as otherwise provided in paragraph (g) of section 10, the issuance of revenue bonds under this act shall not directly, indirectly or contingently obligate the commonwealth or any political subdivision thereof to levy or to pledge any form of taxation therefor or to make any appropriation for payment of those bonds.
SECTION X. There shall be a special commission to identify the capital needs of the community hospital sector with regard to use of technology and adequacy of facilities, the ability of the sector to meet the health care needs of the general population in the next decade, and potential sources of capital to meet those needs. Said Commission shall also evaluate the role of public programs, payments and regulations in supporting capital accumulation and make recommendations to advance the ability of the community hospital sector to meet the expected demand. Said Commission shall be comprised of the Secretary of Health and Human Services, the Commissioner of the Department of Public Health, the Secretary of Administration and Finance, the Commissioner of the Department of Medical Assistance, a representative of the Massachusetts Council of Community Hospitals, a representative of the Massachusetts Hospital Association, a representative of the Associated Industries of Massachusetts, a representative of the Massachusetts Business Roundtable, the chief executive officer of the Massachusetts Health and Educational Facilities Authority, the chief executive officer of Mass Development, the House and Senate Chairs of Ways and Means, the House and Senate Chairs of the Joint Committee on Health Care Financing, and a member of the minority party in both the House and Senate, appointed by the House and Senate Minority Leaders, a chief elected local official with a community hospital located in said community to be appointed by the Governor, an individual knowledgeable about demographic trends and

hospital utilization to be appointed by the Governor and an individual knowledgeable about hospital finance and construction to be appointed by the Governor.
SECTION X. Said Commission shall hold hearings and issue a report to the General Court no later than December 31, 2011.
SECTION X. Notwithstanding the provisions of any general or special law to the contrary, the department of public health shall conduct a study of the commonwealth's community hospitals, with a particular focus on outmigration of patients and related trends, including but not limited to an examination of observed effects and their potential causes with respect to the following:
(1) The impact on individual community hospitals caused by the opening of additional health care services by providers within the primary service areas of such community hospital, in terms of changes in the number and types of procedures performed and changes in revenues;
(2) Recruitment and retention of personnel; and
(3) Changes in payer mix.
The department shall issue a report summarizing its findings and making recommendations with respect to strengthening community hospitals not later than December 31, 2009, and shall file such report with the joint committee on health care financing."
The amendment was adopted.
Mr. Tarr moved to amend the committee bill by striking section 45.
Mr. Tisei rose to a point of order, which, being stated, was would the fact that section 45 was in the bill to begin with make this bill a money bill.
The President stated that the section would not create a money bill and the point of order was not well taken.
After debate on the amendment, the question on adoption of the amendment was determined by a call of the yeas and nays, at thirteen minutes past four o'clock P.M., on motion of Mr. Knapik, as follows, to wit (5 yeas – 31 nays) [Yeas and Nays No. 243]:
INSERT ROLL CALL 243
The yeas and nays having been completed at eighteen minutes past four o'clock P.M., the amendment was rejected.
Mr. Tarr moved to amend the committee bill by adding at the end thereof the following new section:-
"SECTION XX. Section 3 of chapter 176Q of the general laws is hereby amended by inserting after subsection (t) the following paragraph:- 'Nothing in this section shall be construed to authorize the Connector to actively solicit potential participants in their health insurance plans if such participants already have coverage from private companies'."
The amendment was rejected.
Messrs. Tarr and Hedlund moved to amend the committee bill by inserting at the end thereof the following section:-
"SECTION X. Section 15A of Chapter 176Q of the General Laws is hereby amended by striking the last sentence and inserting in place thereof the following:- 'The commission shall commence its meetings no later than September 1, 2010, and shall report its findings and recommendations, including recommendations for proposed legislation, at least annually, to the clerks of the senate and house of representatives; provided, that the first report shall be delivered no later than March 1, 2011'."
After remarks, the amendment was adopted.
Messrs. Tarr and Hedlund moved to amend the committee bill by adding at the end thereof the following new section:-
"SECTION X. Subsection (s) of section 3 of chapter 176Q of the general laws is hereby amended by inserting at the end thereof the following:- "provided, that notwithstanding section 2(d) of this chapter, no changes to the regulations defining minimum creditable coverage shall go into effect until 90 days after the connector gives notice of the changes to the joint committee on health care finance, the joint committee on public health, the senate and house of representatives committees on ways and means, and the clerks of the senate and house of representatives".
After remarks, the amendment was adopted.
Mr. Tisei moved to amend the committee bill by inserting at the end following: -
"Section 8 of chapter 176Q, as inserted by chapter 58 of the acts of 2006 is hereby amended by inserting at the end thereof the following: -'The connector shall not utilize any of the data received from the department for any solicitations or advertising'."
The amendment was adopted.
Mr. Montigny moved to amend the committee bill by inserting at the end thereof the following new section:-
"SECTION____. Section 2 of chapter 111M of the General 38 Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after subsection (c) the following subsections:
(d) The affordability schedule set by the board of the connector pursuant to subsection (a) shall be subject to the following requirements:
(1) in determining whether creditable coverage is affordable, the board of the connector shall consider expected enrollee expenditures as the 90t h percentile of out of pocket costs plus premiums for those enrolled in creditable coverage;
(2) For the purposes of this section, "out of pocket costs" shall mean the amount paid by an enrollee to satisfy the applicable annual deductible, co–payments and coinsurance, not including monthly premiums."
After remarks, the question on adoption of the amendment was determined by a call of the yeas and nays, at twenty-three minutes past four o'clock P.M., on motion of Mr. Montigny, as follows, to wit (36 yeas – 0 nays) [Yeas and Nays No. 244]:
INSERT ROLL CALL 244
The yeas and nays having been completed at twenty-seven minutes past four o'clock P.M., the amendment was adopted.
Ms. Jehlen moved that the committee bill be amended by striking out section 2 and inserting in place thereof the following new section:-
"SECTION 2. Chapter 29 of the General Laws is hereby amended by inserting after section 2AAAA the following section:-
Section 2BBBB. There shall be established and set up on the books of the commonwealth a separate fund to be known as the

High Risk Reinsurance Trust Fund. The commissioner of insurance, in consultation with the secretary for administration and finance and the secretary of health and human services, shall administer a reinsurance program for high-risk individuals covered under products issued in accordance with M.G.L. c. 176J and shall approve the amounts assessed on payers under the same methodology established in section 38 of chapter 118G. Those assessments shall be collected in a manner consistent with said chapter 118G; provided, however, that to the extent federal financial participation is received, the commissioner shall adjust the amount assessed accordingly. The commissioner of insurance shall appoint 7 representatives of carriers issuing or renewing products in accordance with M.G.L. c. 176J to be a members of a Board to develop a Plan of Operations of such high-risk reinsurance program and to monitor the functioning of the program. The commissioner of insurance, in consultation with the secretary for administration and finance and the secretary of health and human services, shall approve the plan of operations of the reinsurance program, the level of reinsurance sponsored by the program, any premium charged for reinsurance, the manner by which expenditures shall be made from the fund to reimburse carriers, as defined section 1 of chapter 176J, for all costs that the carriers may incur in claims under section 12 of said chapter 176J, and the level of assessments necessary to pay for costs that are not covered by any reinsurance premiums. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund. The commissioner of insurance shall promulgate regulations as necessary to implement this section. The commissioner of insurance shall, not later than October 1 of each year, file a written, detailed report with the joint committee on health care financing, the joint committee on financial services, and the house and senate committees on ways and means regarding the methodology and mechanism used in ascertaining any assessments, the methodology used for reimbursing eligible carriers, and the disbursements made by carrier and amount, for the fiscal year ending on the preceding June 30."

The amendment was adopted.

Mr. Morrissey moved to amend the committee bill in section 34, by striking out, in lines 566-569, the following clause:-

"(iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval."

The amendment was rejected.

Mr. Michael O. Moore moved to amend the committee bill by striking out section 33 and inserting in place thereof the following section:-

"SECTION 33. Subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:

(1) a list of health care providers in the carrier's network, organized by specialty and by location and summarizing on its internet website for each such provider: (i) the method used to compensate or reimburse such provider, including details of measures and compensation percentages tied to any incentive plan or pay for performance provision; (ii) the provider price relativity, as defined in and reported under section 6 of chapter 118G; (iii) the provider's health status adjusted total medical expenses, as defined in and reported under said section 6 of said chapter 118G; and (iv) current measures of the provider's quality based on measures from the Standard Quality Measure Set, as defined in the regulations promulgated by the department of public health under section 25P of chapter 111; provided, however, that if any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner; provided, further, that the carrier shall prominently promote providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices."

The amendment was adopted.

Messrs. Morrissey and Hart moved to amend the committee bill by inserting the following 4 sections:-

"SECTION 61. Section 15 of chapter 176O of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof the following subsection:-

(e) A carrier may condition coverage of continued treatment or emergency inpatient or outpatient services by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment, or 120 percent of the then current published rate for the service rendered as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act, whichever is lower, as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider. A provider shall not bill an insured for any portion of continued treatment or emergency inpatient or outpatient services that are not covered benefits under this subsection.

SECTION 62. Said section 15 of said chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out subsection (e) and inserting in place thereof the following subsection:-

(e) A carrier may condition coverage of continued treatment by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant

to a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.
SECTION 63. Section 1 shall take effect on June 1, 2010.
SECTION 64. Section 2 shall take effect on January 1, 2014."
The amendment was rejected.
Mr. Tisei moved to amend the committee bill by inserting the following four sections:-
"SECTION X. Section 15 of chapter 176O of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof the following subsection:-
(e) A carrier may condition coverage of continued treatment or emergency inpatient or outpatient services by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment, or 120 percent of the then current published rate for the service rendered as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act, whichever is lower, as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider. A provider shall not bill an insured for any portion of continued treatment or emergency inpatient or outpatient services that are not covered benefits under this subsection.
SECTION X. Said section 15 of said chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out subsection (e) and inserting in place thereof the following subsection:-
(e) A carrier may condition coverage of continued treatment by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.
SECTION X. Section 1 shall take effect on June 1, 2010.
SECTION X. Section 2 shall take effect on January 1, 2014."
The amendment was rejected.
Mr. Michael O. Moore moved to amend the committee bill in section 23, line 407, by inserting at the end thereof, the following words:- ";provided further, that providers of lowest cost are not discriminated against."; and by inserting in the same section, line 465, at the end thereof, the following words:- "; provided further, that providers of lowest cost are not discriminated against".
The amendment was rejected.
Messrs. Hedlund and Tarr moved that the committee bill be amended by adding the following section:
"SECTION XX: Section 1: Subsection (s) of Section 3, of Chapter 176Q as found in the 2008 edition of the Massachusetts General Laws is amended by striking out the subsection in its entirety and replacing it with the following language: (s) to define and set by regulation minimum requirements for health plans meeting the requirement of "creditable coverage" as used in section 1 of chapter 111M, provided however that no regulation shall be adopted that requires a self-insured individual to purchase prescription drug insurance.
Section 2: Section 2, of Chapter 111M, as found in the 2008 edition of the Massachusetts General Laws is amended by adding the following subsection:
(d) This section shall not apply to any self-insured individual if the individual's health plan meets creditable coverage criteria as defined in Section 1 of Chapter 111M, but does not include a prescription drug coverage benefit.
The amendment was rejected.
Messrs. Morrissey, O'Leary and Hart moved to amend the committee bill in section 23, by inserting after the word "tier", in line 415, the following words:- "or add new providers to its selective and tiered plans".
After remarks, the amendment was adopted.
Ms. Flanagan moved to amend the committee bill in section 3, line 32, after the words "section 1", by inserting the following words:- ", or otherwise licensed under chapter 112,"; and in section 48, line 943, after the words "physician groups", by inserting the following words:- "other health care providers licensed under chapter 112".
The amendment was adopted.
Ms. Tucker moved to amend the committee bill in section 34 by inserting at the end thereof the following :-"; or (4) requires the carrier to enter into an exclusive contracting arrangement with the health care provider, thereby excluding otherwise qualifying health care providers based on their quality and relative prices in a specified geographic market from participation in the carrier's contracted network."
The amendment was rejected.
Mr. Tarr and Ms. Jehlen move to amend the committee bill by inserting at the end thereof the following sections:-
"SECTION X. Section 108 of chapter 175 of the general laws is hereby amended by inserting in subsection A, after the first paragraph, the following paragraphs:-

‘The benefits provided shall be considered presumptively reasonable if the insurer elects to limit its aggregate medical loss ratio for the policy offered to not less than 88 percent, and to limit the amount of any load in the rate for profit and surplus to no more than 1 percent. An insurer making such election shall do so, in writing, to the commissioner when the insurer files its policy. An insurer making such election shall notify all its policyholders in writing at the time of making such election that it has made such election.

An insurer making an election under this subsection shall regularly and as requested by the commissioner file with the commissioner documentation reporting that the annual aggregate medical loss ratio for any policy approved under this chapter and the annual aggregate amount of any contribution to profit or surplus derived from any policy offered under this chapter complies with regulations promulgated by the commissioner.

If the annual aggregate medical loss ratio for any policy offered under this chapter is less than 88 percent over the applicable 12 month period, the insurer shall refund the excess premium to its eligible policyholders. An insurer must communicate within 30 days to all policyholders that were covered under plans during the relevant 12 month period that such policyholders qualify for a refund to be issued under this paragraph, which may take the form of either a refund on the premium for the applicable 12 month period, or if the policyholders are still covered by the insurer, a credit on the premium for the subsequent 12 month period. The total of all refunds issued shall equal the amount of an insurer’s earned premium that exceeds that amount necessary to achieve a medical loss ratio of 88 percent, calculated using data reported by the insurer as prescribed under regulations promulgated by the commissioner. The commissioner may authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds would result in financial impairment for the insurer.

The commissioner shall conduct an annual public hearing on the implementation of this subsection and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell or shall notify such newspapers of the hearing. The attorney general shall be authorized to intervene in any public hearing or other proceeding under this subsection and may require additional information as the attorney general considers necessary to ensure compliance with this subsection.

The commissioner shall adopt any regulations required under this section.

SECTION XX. Section 108 A of chapter 175 is hereby amended by striking out the figure ‘88’ each time that it appears and inserting in place thereof the following figure:- ‘90’.

SECTION XXX. Section XX shall go into effect July 1, 2011.”

The amendment was rejected.

Mr. Tisei moved to amend the committee bill by inserting at the end thereof the following: -

“SECTION 1: Chapter XXX is hereby amended by adding the following new section:

Chapter XX: Contracts Between Hospitals and Payors

As used in this section, the following words shall have the following meanings:

‘Maximum Relative Price for Care’: A rate that is equal to 110 percent of the Payor’s total statewide average reported price for combined and weighted inpatient and outpatient services paid to Hospitals in the Payor’s network. This rate shall reflect all discount-off-charges and all supplemental payments to the hospital.

‘Payor’: carrier, as defined by M.G.L. Chapter 176O, the group insurance commission established under chapter 32A; and to the extent legally feasible and otherwise not prohibited by any applicable provision of the Employee Retirement Income Security Act of 1974, other employee welfare benefit plans.

(a) Every acute care hospital, licensed in the commonwealth, which provides covered services to a person, and meeting the requirements of subsection (b), and every Payor in the commonwealth shall renegotiate the existing contracts to provide covered services to a person such that the new contract rates for calendar year 2010 and subsequent years until the expiration of the contract term remain at the contract rates for calendar year 2009. If the hospital is part of a consolidated system, each facility in the system shall negotiate a separate rate with the payor. For purposes of this Section “facility” shall mean the individual physical structure for a licensed acute care hospital where services are provided to an individual.

(b) Every Payor shall identify the hospitals in their network that exceed the carrier’s Maximum Relative Price for Care and that are entities within a consolidated system and submit the list of hospitals to the Office of the Attorney General, within 10 days of the effective date of this Act. Each Payor shall separately calculate and identify the Maximum Relative Price for Hospitals offering services through their products offered under Chapter 176G and 176I. Following submission by the Payor, the Office of the Attorney General shall, within 15 days of the effective date of this Act, notify those hospitals of their requirement to enter into negotiations with each payor, as required under this section; provided that the Attorney General shall include only those hospitals that have been identified as in good financial condition, as defined in subsection (c) of this Section.

(c) For the purposes of determining whether a hospital is in good financial condition, the consolidated system of which the hospital is a part shall meet the following criteria:

1. The consolidated system has a system-wide five year (2005-2009) average total margin of at or above 4 percent;
2. The consolidated system has produced system-wide positive operating margins in three of the last four years (2006-2009);
3. The consolidated system has a five year average debt service coverage ratio of at least 3.00 (2005-2009); and
4. The consolidated system has at least 100 days of unrestricted cash on hand as of calendar year (or hospital fiscal year?) 2009, this shall include all cash and marketable securities that are not donor-restricted or trustee-held.

(d) Notwithstanding any general or special law to the contrary, from the date of expiration of the contract subject to the provisions of paragraphs (a) through (c) of this section until such time as global payments replace fee-for-service as the predominant payment methodology in the Commonwealth, as determined by the Attorney General in consultation with the

Special Commission on Payment Reform established pursuant to Chapter 305 of the Acts of 2008, the reimbursement rate to acute care hospitals from Payors shall not exceed a rate equal to 130 percent of the Medicare reimbursement rate for those services as if they were rendered to a Medicare beneficiary not taking into consideration any beneficiary cost sharing."
The amendment was rejected.
Messrs. Tolman, Baddour, Tarr, Ms. Menard, Ms. Candaras, Messrs. O'Leary, Donnelly, Montigny and Joyce moved to amend the committee bill by striking out section 45 and inserting in place thereof the following section:-
"SECTION 45. (a) Notwithstanding any special or general law to the contrary, tier 1 and tier 2 participating providers shall contract with a carrier to provide one-time supplemental funding for the purposes of issuing refunds for all health benefit plans issued to eligible individuals and small groups under chapter 176J of the General Laws. The refund may take the form of either a refund on the premium for the applicable 12-month period or another form agreed upon by the parties by contract.
(b) For purposes of this section a tier 1 participating provider is an acute care hospital licensed by the department of public health that, based on the most recent cost report it filed with the division of health care finance and policy, referred to in this section as the applicable cost report, had an annual operating margin greater than 2.5 per cent in each of the past 2 years and that received more than 50 per cent of its net patient service revenue from private carriers; provided however, that the operating margin shall be calculated through a consolidated system financial statement.
(c) For the purposes of this section a tier 2 participating provider is an acute care hospital licensed by the department of public health that based on the most recent cost report it filed with the division of health care finance and policy, had an annual operating margin greater than 2.5 per cent in each of the past 2 years and that received more than 35 per cent and less than 50 per cent of its net patient service revenue from private carriers; provided however, that the operating margin shall be calculated through a consolidated system financial statement.
(d) The state-wide aggregate amount of one-time supplemental funding generated under this section from all contracts between participating providers and carriers may not exceed $100 million. Each tier 1 participating provider's pro rata share of this aggregate amount shall be equal to 1.25 per cent of such participating provider's net patient service revenue, as determined from the applicable cost report, or such lesser percentage as may be determined by the division of health care finance and policy. Each tier 2 participating provider's pro rata share of the state-wide aggregate amount shall be equal to 0.75 per cent of such participating providers net patient service revenue, as determined from the applicable cost report, or such lesser percentage as may be determined by the division of health care finance and policy. The division of health care finance and policy may audit the books and records of each such participating provider to assure compliance with this subsection.
(e) The division of health care finance and policy may exempt an acute care hospital from its total assessment obligation or a portion of the total assessment obligation based on financial hardship criteria to be developed within 30 days of the effective date of this act; provided however, that a participating provider with less than 25 days of net working capital shall be exempt. The financial hardship criteria shall include, but shall not be limited to, a review of the participating provider's role in providing critical services within a geographic area, the ability of the provider to finance necessary capital projects, the efficiency and relative prices of the provider, the amount of provider expenditures for community based programming, a provider's status as a community disproportionate share hospitals, the provider's level of reserves and endowments, any impact on the provider by the February 10, 2010 amendments to 211 CMR 43.08, any contract amendments or price reductions made on or after October 1, 2009, the percentage of net patient revenue from the Commonwealth Care Health Insurance Program and from organizations providing managed care pursuant to the Medicaid program defined in section 8 of chapter 118E, and the provider's activities to reduce health care costs through the better management of care and utilization.
(f) Funds generated under this section shall be designated for the purpose of reducing health insurance premiums for eligible individuals and small groups in the commonwealth. Participating providers and carriers may develop a schedule for transfers by contract, by September 30, 2010, provided that all transfers are completed on or before September 30, 2012. The division of insurance shall require the filing of such contracts after execution for the purposes of ensuring distribution as provided in the contracts. Each carrier that is a party to such a contract shall report to the division of insurance, at least quarterly and in such form as the division of insurance shall require, the amount of one-time supplemental funding it has received from each participating provider and how such supplemental funding shall be refunded to eligible individuals and small groups under chapter 176J of the General Laws; and shall certify to the division of insurance, at least quarterly in such form as the division of insurance shall require, that it has made distribution of such supplemental funding in accordance with the terms of the applicable contracts. The division of insurance may audit the books and records of each such carrier to assure compliance with the terms of each certification that it files. The division of insurance shall issue a public report by October 1, 2010 detailing the participating providers who have entered into such contracts, the amount of one-time supplemental funding by participating provider and the estimated aggregate refunds to be provided to eligible individuals and small groups. The commissioner of insurance may promulgate regulations as necessary to implement this section.
(g) A tier 1 or tier 2 participating provider shall be exempt from payment obligations under this section, if such provider either: (1) amends its existing contracts with carriers to provide the same level of financial relief as the assessment obligation defined by the division of health care finance and policy, or (2) amends its existing contracts carriers to limit the rate of increase of any inflation adjustment to rates equal to or less than to the most recent published rate for medical care inflation in the northeastern United States, by the Bureau of Labor Statistics. The tier 1 and tier 2 participating provider and relevant carrier shall jointly provide the division of insurance with a statement that the parties to the contract have amended their contract.
The method of payments and specific adjustments required to qualify for the exemption shall be determined by the parties to the contract. The division of insurance shall establish procedures to assure that the financial value of an amendment to a contract under this subsection benefits employers and individuals purchasing health care coverage from a carrier on or before September

30, 2012.
The division of insurance may require additional information from participating providers as necessary to ensure compliance with this section.
(h) This section shall not be construed as a benchmark or other rationale to oppose continued efforts to constrain health care costs through negotiation between providers and carriers.
The amendment was adopted.
Ms. Tucker and Mr. Montigny moved to amend the committee bill by inserting at the end thereof the following new section:-
"SECTION X. The commissioner of the division of insurance and the office of the attorney general shall report to the House and Senate Committees on Ways and Means and the Joint Committees on Health Care Finance and Policy not later than January 1, 2012 on the effectiveness of limited and tiered networks related to the small group market. The report shall include, but not be limited to, an analysis of the savings that tiered or limited networks create for the small group market, an analysis of consumer impacts including the desirability of enrollment, consumer access to primary, secondary, and mental health care services, medical utilization, and quality of care; an analysis on whether it is necessary to allow carriers to exclude providers of the same or similar level of quality, as measured by the standard quality measure set, from tiered or limited networks that will accept the same levels of geographically-adjusted reimbursement that providers in the tiered or limited network accept and analysis of whether it is financially necessary to exclude said providers and the implications on the financial stability of excluded providers; an analysis of whether said non-contracted providers should have the right to join the limited or tiered network if the provider willingly accepts the geographically-adjusted rates for services agreed to in the limited or tiered network; an analysis on the impact of so-allowing such non-contracted providers to join said limited or tiered networks to encourage consumer enrollment in said networks and the implications for enhanced cost savings through enhanced enrollment; and an analysis on the impact of so-allowing such non-contracted providers to join said limited or tiered networks on the sustainability of limited and tiered networks as a method of reducing premiums for the small group markets."
The amendment was adopted.
Messrs. Tarr and Tisei moved to amend the committee bill by striking out section 40 and inserting in place thereof the following section:-
"SECTION 40. (a) Notwithstanding any general or special laws to the contrary, there shall be a special commission to examine proposals to reform the merged market to produce premium reductions, which shall include limitations on rating adjustment factors and the establishment of a reinsurance pool.
(b) The commission shall consist of the commissioner of insurance, who shall serve as chair; the secretary of administration and finance; the commissioner of health care finance and policy; and 4 members to be appointed by the governor, 3 of whom shall represent carriers and 1 of whom shall be an actuary in good standing with the American Society of Actuaries.
(c) The commission shall conduct a study, which shall include examining the impact of establishing a reinsurance pool for carriers issuing health benefit plans under chapter 176J, including the potential impact of a carrier funded reinsurance pool on individual carriers, the potential impact on the competitive balance in the marketplace and the potential aggregate impact on premiums for eligible individuals and eligible small groups. The commission shall make recommendations for a plan of operation for the reinsurance pool to be implemented under section 12 of chapter 176J of the General Laws that will maximize federal funding and provide the greatest reduction in premiums for eligible individuals and eligible small groups. The recommendations shall also include, but shall not be limited to: the source of the funding, the level of funding sufficient to produce reductions in premiums for the small-group health insurance market, the amount necessary for the assessment and deposit into the High Risk Reinsurance Trust Fund established in section 2BBBB of chapter 29 of the General Laws, the appropriate level of reimbursement to carriers under section 12 of chapter 176J of the General Laws and the initial threshold and upper limit used in said chapter 176J. The report shall take into account the following factors:
(1) the financing of the pool through an assessment on surcharge payers under section 38 of chapter 118G of the General Laws;
(2) the availability of federal financing through the federal Patient Protection and Affordable Care Act; and
(3) the experience of other states in designing and implementing reinsurance pools or high risk pools.
(d) The commission shall also conduct a study, which shall review the rating factors as permitted by section 3 of chapter 176J of the General Laws to determine the impact of the application of each rating factor on premiums of eligible individuals and eligible small groups. As part of its analysis, the commission shall examine the extent to which establishing a limit on the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive of subsection (a) of said section 3 of said chapter 176J, shall result in an increase to a carrier's base premium rate for the individual and small group insurance market. The report shall include a detailed analysis of the impact of said limits on a carrier's base rate premium and shall include estimates of the percentage increase to a carrier's base rate premiums attributable to a range of limits on adjustment factors.
(e) The commission shall also conduct a study, which shall examine the impact of limiting the availability of new individual health plans to those offered through the commonwealth health insurance connector authority. The commission shall examine the current plan offerings available to individuals as compared to plan offerings available through the commonwealth health insurance connector authority. The study shall also examine the ability of the commonwealth health insurance connector authority to market the availability of individual plans in conjunction with an annual open enrollment period for eligible individuals. The study shall report on the impact, if any, on premium rates in the merged market as the result of this proposal. In conducting this study, the commission shall consult with the executive director of the commonwealth health insurance connector authority, a representative of an employer association, a representative of a health underwriters association and a representative of a health care consumer group.
(f) For the purpose of conducting these studies, the commission may contract with an outside organization with expertise in fiscal

analysis of the private insurance market. The commission shall establish appropriate guidelines and assumptions regarding the health reforms authorized in this act before engaging an outside organization. In conducting its examination, the organization shall, to the extent possible, obtain and use actual health plan data; provided however, that such data shall be confidential and shall not be a public record.
(g) The commission shall meet not later than July 15, 2010 and shall file a report with the clerks of the senate and house of representatives not later than September 30, 2010."
The amendment was adopted.
Messrs. Baddour, Buoniconti, O'Leary, Downing, Ms. Flanagan, Messrs. Tarr and Petruccelli, Ms. Tucker, Messrs. Timilty, Morrissey and Hart, Ms. Candaras and Messrs. Kennedy, Joyce, Brewer and Pacheco and Ms. Chandler moved to amend the committee bill by inserting after section 13 the following 3 sections:-
"SECTION 13A. Said section 1 of said chapter 176J, as so appearing, is hereby amended by inserting after the definition of 'Prototype plan' the following definition:-
'Qualified association', a Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and dependents of a prospective association member.
SECTION 13B. Said section 1 of said chapter 176J, as so appearing, is hereby amended by inserting after the definition of "Resident" the following definition:-
'Small business group purchasing cooperative', or 'group purchasing cooperative', a Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association by the commissioner under section 13, all the members of which are part of a qualified association which negotiates with 1 or more carriers for the issuance of health benefit plans that cover employees, and the employees' dependents, of the qualified association's members.
SECTION 13C. Said section 1 of said chapter 176J, as so appearing, is hereby amended by adding the following definition:-
'Wellness program', or 'health management program', an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.; ." and in section 25 by adding the following 2 sections:-
"Section 13. (a) The commissioner shall promulgate regulations governing the establishment and oversight of small business group purchasing cooperatives. The regulations shall require: (i) that all state-mandated benefits are required under plans procured by approved small business group purchasing cooperatives; (ii) that all such plans offer its enrollees access to wellness programs which, at a minimum, shall be actuarially similar to wellness programs that may be offered through the commonwealth health insurance connector authority; (iii) that the group purchasing cooperative obtain a commitment from 50 per cent of its covered employees that the employees will enroll in the health management programs that the group purchasing cooperative provides; (iv) that the group purchasing cooperative establish reasonable systems, which shall comply with any applicable sections of the Americans with Disability Act and any other federal requirements, under which enrollees can record their participation in, and group purchasing cooperatives can monitor enrollees' participation in, available health management programs; (v) that denial of coverage due to the health condition, age, race or sex of the employees and dependents of qualified association members in a group purchasing cooperative is prohibited; and (vi) that no eligible qualified association member of a small business group purchasing cooperative may be charged a premium rate higher than what the carrier would charge to a similarly-situated eligible small business that is not a participant in a small business group purchasing cooperative.
(b) The commissioner shall promulgate regulations governing the application and certification process that a proposed small business group purchasing cooperative shall undergo before the commissioner may certify the group purchasing cooperative as a small business group purchasing cooperative approved to operate in accordance with this section; provided, however, that the commissioner shall only certify 4 group purchasing cooperatives to operate at any given time; provided further, that the commissioner shall certify any application that meets the requirements of this section up to and until the commissioner has certified 4 group purchasing cooperatives. The commissioner shall limit the number of applications that are approved for each small business group cooperative so that in a given year, the total number of covered lives, for each approved group purchasing cooperative, shall not exceed 15,000 lives. Notwithstanding the provisions of this section, once the limit on covered lives is reached, the commissioner shall not approve the application of a new group purchasing cooperative until a previously approved group purchasing cooperative disbands or until the commissioner disapproves a group purchasing cooperative's annual renewal for failure to comply with the terms of this section and any regulations promulgated in accordance with this section.
(c) The commissioner shall annually certify that a small business group purchasing cooperative satisfies the requirements of this section. Only a small business group purchasing cooperative that has been certified by the commissioner may procure health care coverage for the benefit of qualified association members.
(d) The commissioner shall review the books and records of a small business group purchasing cooperative and the methodology which it confirms the status of qualified associations.
(e) Health care coverage procured by a small business group purchasing cooperative shall be sold to qualified association members and may be sold through duly licensed agents, the commonwealth health insurance connector authority or brokers.
(f) Member-employers of qualified associations purchasing health coverage within a group purchasing cooperative shall not have more than 50 eligible employees.
(g) The commissioner, in consultation with the division of health care finance and policy and the commonwealth health insurance

connector authority, shall report and make recommendations, as necessary, on the cost savings to the qualified association members that participate in small business group purchasing cooperatives, the impact, if any, on the establishment of small business group purchasing cooperatives to the risk pool and premium costs in the merged market, and whether the authority of the commissioner to certify small business group purchasing cooperatives should be renewed to the house and senate committees on ways and means and the joint committee on health care financing and financial services within 24 months of the first certification of a small business group purchasing cooperative as defined under this section.

Section 14. (a) As a condition of continued offer of small group health, a carrier that, as of the close of a preceding calendar year, has a combined total of at least 5,000 eligible individuals, eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals shall be annually required to file a plan with each group purchasing cooperative for its consideration if a group purchasing cooperative requests such health plan proposals for its next plan year.

(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply preexisting condition limitations and waiting periods in the same manner as the carrier applies them to small group products offered outside the group purchasing cooperative; (iii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iv) apply continuation of coverage provisions in the same manner as the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (v) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (vi) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative; provided, that such plans may make limited deviations from these rating factors with the prior approval of the commissioner.

(c) Carriers shall comply with a group purchasing cooperative's wellness program's data processing systems to provide information that will enable the group purchasing cooperative to effectively provide guidance to members on targeted wellness programs."; and by inserting after section 54 the following section:-

"SECTION 54A. The commissioner's authority to certify small business group purchasing cooperatives under section 13 of chapter 176J of the General Laws shall expire on December 31, 2014."

After remarks, the question on adoption of the amendment was determined by a call of the yeas and nays, at eight minutes past five o'clock P.M., on motion of Mr. Tarr, as follows, to wit (36 yeas – 0 nays) [Yeas and Nays No. 245]:

INSERT ROLL CALL 245

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

Mr. Panagiotakos moved to amend the committee bill by striking out, in line 31, the word "25I" and inserting in place thereof the following word:- "25O"; by striking out, in line 32, the word "25J" and inserting in place thereof the following word:- "25P"; by inserting, in line 97, after the words "uniform methodology" the following words:- ", provided that, the division shall require the submission of data and other such information from each acute care hospital"; by inserting, in line 100, after the words "annual basis" the following words:- "; provider, that at least 10 days prior to the public posting or reporting of provider specific information the affected provider shall be provided the information for review"; by inserting, in line 168, after the words "claims incurred" the following words:- "and other allowable expenses"; by striking out section 16 and inserting in place thereof the following section:-

"SECTION 16. Clause (1) of subsection (a) of section 4 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following 3 sentences:- Every carrier shall make available to every eligible small business every eligible health benefit plan, including a certificate that evidences coverage issued or renewed to a trust or association, that it makes available to any other eligible small business. A carrier that offers health benefit plans to eligible small groups, as defined by chapter 176J, shall: (i) participate in the nongroup health insurance market by selling nongroup insurance, and (ii) sell nongroup health insurance solely through the connector, as defined in chapter 176Q, and (iii) shall make available to every individual and their eligible dependents every health benefit plan that it makes available to any other eligible individual and small groups through said connector. A carrier may make available to eligible small businesses health benefit plans that are not made available to eligible individuals.";

By striking out section 19 and inserting in place there of the following section:-

"SECTION 19. Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:

(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the division of insurance when such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12; provided that, cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the division of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter."; and in section 20, by striking out proposed subsection (a) of section 6 of chapter 176J of the General Laws and inserting in place thereof the following subsection:-

"(a) Notwithstanding any general or special law to the contrary, health benefit plans to be provided to eligible individuals or eligible small businesses and all changes to plan base rates, rating factors and administrative costs shall be submitted to the

division of insurance and shall be subject to the approval of the commissioner.";
In said section 20, in the first paragraph of proposed subsection (e) of said section 6 of said chapter 176J by adding the following sentence:-
"Nothing in this subsection shall be construed to limit the commissioner's authority to disapprove rates under chapter 175, 176A, 176B, or 176G.";
In said section 20, in said section 6 of said chapter 176J, by adding the following subsection:- "(g) If the commissioner disapproves the rate submitted by a carrier under subsections (d) or (e), the commissioner shall notify the carrier in writing no later than 45 days prior to the effective date of the carrier's rate. The carrier may request a hearing on the disapproval to be held within 15 days of the notice by filing a written request with the division of insurance within 10 days of its receipt of such notice. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision."; by inserting in line 395, after the words "small businesses" the following words:- in at least 1 geographic area; by inserting in line 417, after the word "provide" the following word:- affected; in line 425, by striking out the words "geographic and socioeconomic information" and inserting in place there of the following words:- "and geographic information"; in line 435, after the words "small businesses" the following words:- "in at least 1 geographic area"; in line 475, after the words "must provide" the following word:- "affected"; in lines 482 and 483,by striking out the words "and socioeconomic"; by striking out section 26; by striking out, in lines 895 and 896, the words "specify a uniform method for allocating expenditures as medical claims or administrative expenses, including, but not limited to:" and inserting in place thereof the following words:- ", specify a uniform method for determining whether and to what extent an expenditure shall be considered a medical claims expenditure or an administrative costs expenditure, which shall include, but not be limited to, a determination of which of these classes of expenditures the following expenses fall into: "; by inserting, in line 906, after the words "Plans" the following words:- "; the Massachusetts Medical Society Alliance, Inc.; the Massachusetts Hospital Association, Inc.; Health Care for All, Inc."; and by striking out section 52, and inserting in place thereof the following section:-
"SECTION 52. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall convene an administrative simplification working group consisting of the following members: the secretary of consumer affairs and business regulation or the secretary's designee, the commissioner of health care finance and policy or the commissioner's designee, the commissioner of public health or the commissioner's designee, the commissioner of insurance or the commissioner's designee, the commissioner of revenue or the commissioner's designee, the director of the office of Medicaid or the director's designee, the attorney general or the attorney general's designee, the inspector general or the inspector general's designee, a representative of the Massachusetts Health Data Consortium, a representative of the Health Care Quality and Cost Council, a representative of the Massachusetts Hospital Association, Inc., and the executive director of the commonwealth health connector authority or the executive director's designee. The group shall identify ways to streamline state created or mandated administrative requirements in health care, including ways to reduce health care reporting requirements through maximizing the use of a single all-payer data base, as administered by the division of health care finance and policy. The group shall hold its first meeting not later than January 1, 2011 and shall issue a report on or before April 1, 2011. The report shall include specific steps to be taken by each agency and the agencies collectively to reduce administrative and filing requirements on health carriers and health care providers, which shall include, but not be limited to, an interagency agreement to use where necessary, the all-payer claims data base, and to streamline and coordinate all requests for all other data requests from health care providers and health plans in the commonwealth.";
In the second sentence of the first paragraph of section 54, as amended by amendment 18, by inserting after the word "group", the following words:- "; a representative of an association of health care providers licensed under chapter 112 of the General Laws who is not a medical doctor"; by striking out Section 55, and inserting in place thereof the following section:-
"Section 55. Sections 1, 3 to 7, inclusive, 9 to 15, inclusive, 17, 19, 20, 23, sections 13 and 14 of chapter 176J of the General Laws as inserted by section 25, 31, 34, 39 to 42, inclusive, and 44 to 54D, inclusive, shall take effect on July 1, 2010.";
By striking out Section 56, and inserting in place thereof the following section:-
"Section 56. Sections 1A, 1B, 2 and section 12 of chapter 176J of the General Laws as inserted by section 25 shall take effect on October 1, 2010.";
By striking out Section 58, and inserting in place thereof the following section:-
"Section 58. Sections 4A, 18, 21, 24, 33 and 38 shall take effect on July 1, 2011.";
and, by striking out section 59, and inserting in place thereof the following section:-
"Section 59. Sections 8, 16, 26 to 30, inclusive, 36, 37 to 43, inclusive, shall take effect on July 1, 2012.".
The amendment was adopted.
The bill, as amended was then ordered to a third reading and read a third time.
After debate, the question on passing the bill to be engrossed was determined by a call of the yeas and nays, at twenty-seven minutes past five o'clock P.M., on motion of Mr. Richard T. Moore, as follows, to wit (yeas 33 – 4 nays) [Yeas and Nays No. 246]:
INSERT ROLL CALL 246
The yeas and nays having been completed at twenty-nine minutes before six o'clock P.M., the bill was passed to be engrossed [For text of the bill as amended, see Senate, No. 2447, printed as amended].
Sent to the House for concurrence.

Order Adopted.
On motion of Ms. Menard,
Ordered, That when the Senate adjourns today, it adjourn to meet again on Thursday next at twelve o'clock noon, in a full formal session.

Adjournment in Memory of Former State Representative
Frances Alexander

The Senator from Essex, Mr. Berry, requested that when the Senate adjourns today, it adjourn in memory of Frances Alexander, former State Representative from Beverly, Massachusetts.
In keeping with her life-long philosophy of doing the best with the hand life has dealt you, Frances Alexander, first became involved in politics when a friend asked her in the mid 1960s if she would serve as a poll worker on Election Day. At the time she had four children dependent on her, an absent husband, and the possibility of an extra 25 dollars sealed the deal. Thereafter, she went on to serve six years on the Beverly School Committee, six years on the Beverly City Council, four of which she served as Council President, and eight years as the State representative from Beverly. Frances Alexander took great pride in helping those who needed it, having been there herself, she would often say.
Accordingly, as a mark of respect to the memory of former State Representative Frances Alexander, at twenty-eight minutes before six o'clock P.M., on motion of Mr. Tolman, the Senate adjourned to meet again on Thursday next at twelve o'clock noon.