HEALTH CARE ACCESS AND REFORM BILL
KEY EFFECTIVE DATES AND OTHER DATES
CHAPTER 58 OF THE ACTS OF 2006

** DRAFT **

DATE	PROVISION	Bill Section	MAHP Issue/Concern
APRIL, 2006			
April 12, 2006	Effective Date for Bill – most provisions take effect, including provisions creating new Commissions, Boards, Councils, and Studies.	Various	
	Connector is Authorized	101	
	High-deductible health plan authorization	60	* Language may need to be redrafted for clarification
	Dependent Coverage to 25 authorized	49, 53, 56, 58	* These sections do not share the same effective dates: 1/01/2007: 49, Immediately effective: 53, 56, 58
	Requirements regarding Pre-Existing Condition Exclusions and Waiting Periods effective	83, 84, 97 - 100	* This is first subject to DOI regulation
	Genetic information provision effective	77	
	Insurance Partnership Program (IPP): Self-employed individuals enrolled in IPP are eligible for employee subsidy only	22	* All IPP Effective Dates must be examined
	New Health Access Bureau at DOI	6	
	DOI to publish annually minimum standards for insurance products	7	
	Health Plans must notify all members, at least once annually, of all health plans and pursuant premiums for which members are eligible		* Pursuant to DOI Directive
	HSA state tax deductibility	10	
	MassHealth disability standard criteria limitations, and public hearing and notice before restricting benefits	16, 24	
	MassHealth – Moratorium on changes to BH services, pending report to Legislature and DMH approval of BH changes	113	
	EOHHS Pilot for smoking cessation authorized	108	
	UCP: New Requirements for Free Care Applicants	42	

	UCP: Moratorium on pool regulations effective	125	
	EOHHS study on creation of selective provider networks	109	
	Employer and Employee "Health Insurance Responsibility Disclosure" indicating whether coverage offered and accepted	42	
	"Free Rider" Assessment provision effective	44	* Note that some "Free Rider" provisions and definition not effective until 10/1/2007
MAY, 2006			
May 1, 2006	Special Commission on Merger must meet	114	
JUNE, 2006			
June 11, 2006	EOHHS Implementation Plan and Timeline Due; must also include bi-monthly updates	132	
JULY, 2006			
July 1, 2006	MassHealth expansions effective	Various	
	MassHealth enrollment caps raised	105 – 107	
	Transparency Site is Live	136, 3	
	Plans for closing small group and non-group reinsurance due to DOI	88, 95	* Section 88 effective date should be immediate (strike "7/1/07" effective date for section 88)
	Distressed Provider Trust repealed	103	
	Commonwealth Care health plan criteria published	101	
	Exclusive opportunity for MCO's contracting with state as of this date to offer subsidized plan	123	
AUGUST, 2006			
August 1, 2006	Connector Director to submit plan of operation (and any needed amendments to Chapter 176Q to Connector Board (due date))	133	
SEPTEMBER, 2006			
September 30, 2006	Deadline for Premium assistance schedule to be published annually	45	
	Deadline for publication of the "Commonwealth Care Health Insurance Program Consumer Price Schedule"	101	
OCTOBER, 2006			
October 1, 2006	Employer "Fair Share" Contribution effective (up to $295/employee)	47	
	IPP Expansion to 300% of FPL	19	
	IPP Subsidy consistent with Commonwealth Care	21, 22	* These sections have effective dates of 10/1/2006, and July 1, 2007
	Premium Assistance Payments Remitted	101	
	Commonwealth Care Program	45	

	begins		
DECEMBER, 2006			
December 1, 2006	Deadline (annually) for publication of a premium schedule annually; must include lowest premium on market for which an individual would be eligible	101	
December 31, 2006	Study Commission on Merger Report Due	114	* May need this effective date expedited
JANUARY, 2007			
January 1, 2007	Dependent Coverage Effective	49, 53,56,58	* These sections do not share the same effective dates: 1/01/2007: 49, Immediately effective: 53, 56, 58
	Changes plan requirements with regard to premium setting and rate basis types	82	
	Requires Electronic Rate Filing and other notices to DOI	87	
	Employers to offer "Cafeteria Plans"	48	* Effective Date of "Cafeteria Plan; " small group rating changes should coincide with effective date of merger and individual mandate.
	Policy intended to prevent employers from offering different health plans to different classes of employees or dropping coverage for certain workers takes effect	50, 52, 55, 59	
	Transparency Site must include comparative data	136	
	Effective in January, Plans must annually file product offerings with Connector for Commonwealth Seal of Approval by October 1st	82	
	EOHHS Study on selective networks is due	109	
	Definition and Tech changes take effect in chapters 176J	62, 63, 66, 69, 70, 76	
	Tobacco Use added as Rating Factor	78	* See also section 73 and whether these 2 sections work correctly
FEBRUARY, 2007			
February 1, 2007	Public Health Council composition change	5	
MARCH, 2007			
March 1, 2007	Open Enrollment in Connector Begins	115	Open Enrollment for non-group individuals into 176J is 3/1 to 5/1 without pre-ex or waiting period. *The effective date of coverage must be clarified (7/1 or 4/1/2007?) * Need clarification that Connector products may be sold to non-group individuals using non-group rating rules until July 1, 2007 merger.

APRIL, 2007			
April 1, 2007	Connector begins offering commercial health plans	101	
	Young Adult Health Plans begin	60A, 90	
	Modifies benefit level to include the service delivery and network of a health benefit plan	64	
	Authorizes Restricted Networks	86	
	Eliminates Preferred Provider arrangements from being considered carriers for the non-group and small group markets	65	
	"Modified Community Rate" definition effective	76	* Also has a 1/1/2007 effective date
MAY, 2007			
May 31, 2007	Open enrollment in Connector ends	115	
JUNE, 2007			
June 1, 2007	1st publication (and subsequently to be done annually) of income levels for FP guidelines, and schedule of % of income for each 50% increment of the FPL at which an individual could be expected to contribute income toward purchase of health insurance coverage. Prior to publication, must be shared with House and Senate Health Care Financing and Ways and Means Committees	101	
June 30, 2007	DHCFP report on new UCP payment methodology for FY2008 due		
	Small-group and Non-group reinsurance programs close	88, 95	
JULY, 2007			
July 1, 2007	Individual mandate begins	12	
	Non-group and Small-group markets are merged (and related provisions)	81, 85, 89, 91, 94, 93, 72, 74, 139	
	Moratorium on new mandates begins	127	* Should be effective earlier; clarify legislative intent.
	IPP: Self-employed individuals enrolled in IPP are eligible for employee subsidy only	23	* All IPP dates must be examined
	MassHealth hospital and physician rate increases begin with first $90M installment	128	* Effective date of 7/1/07 may be in error as rate increases are contemplated for FY07.
	Dept. of Labor and DHCFP to report on impact and implementation of "Fair Share Assessment" deadline	134	

OCTOBER, 2007			
October 1, 2007	Recurring deadline for annual health plan filing of Connector plans	82	
	UCP repealed		
	Creation of Health Safety Net Office to replace Pool administration; revisions to Uncompensated Care Pool statute	30	
	Hospital and physician rate increases contingent on meeting performance benchmarks	25	
	Repeals moratorium on Free Care Pool regulations preserving services	126	
JANUARY, 2008			
January 1, 2008	Individual Mandate: penalties assessed for non-compliance	13	
	Mandate Moratorium ends (when DHCFP review is complete, even if later)	127	
	MassHealth and Private Health Plans must provide monthly list of enrollees to DOI	18, 51, 54, 57, 61	

HEALTH CARE REFORM
COMPARISON CHART
*** Draft ***

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
Overall Access and Coverage Goals	- 140,000 Market Reforms - 30,000 IPP Reform - 70,000 Medicaid-Eligible * Goal is to cover ½ of 532,000 Uninsured over the next 2 years		- 106,000 Medicaid-eligible - 150,000 Safety Net Care - 204,000 Commonwealth Care * Goal is to cover 460,000 uninsured	- 163 Medicaid - 220 Private insurance - 123 Subsidized Insurance * Goal is to cover 560K uninsured
		I. INSURANCE MARKET REFORM		
1. Small Group/Non-Group Reform	**Non-Group Reform** - Plans must continue to offer standard plan. - Plans may offer up to 6 alternate plans: (1) their existing alternative plan, (2) up to 3 HSA (high deductible) plans; and (3) up to 2 plans with caps on outpatient services. **Small Group Reform:** - Small Group Review Board to make recommendations on further reform of market, included whether small group should expand to 75 eligible employees. (Sec. 48)	**Ballot Question** - Does Not Merge Non-Group and Small Group **Original Bill** - Merges Non-Group and Small Group - Original bill repeals non-group law, and allows individuals to purchase within the small group market. (Sec. 12, 13 of original bill).	**Merges Non-Group and Small Group** - Repeals non-group law effective 1/1/06. - Creates Exchange, through which individuals can purchase in small group market - As of 1/1/07, requires individuals over 18 to obtain coverage or offer proof of financial security. (See appendix). - Carriers must continue to renew existing non-group plans until membership drops below 25% of 12/31/04 membership. - Existing non-group members can access coverage in merged market beginning 1/1/06. - Combined market will follow small group rating rules as follows: Deletes the 176J rating rules and substitutes: - New language adds geographic area - Rate band of .66 to 1.32 - Adds Age Rate adjustment, not permitted in the old group law after '93 - Adds Industry Rate adjustment, not allowed in old law. - Wellness. New is up to 5% discount. Old was .95 to .99. - Tobacco usage is new and no limit, other than approved by DOI	**Merges Non-Group and Small Group** - Opens small group to non-group members as of July/1/2006. (check sec. 72) - Open enrollment from 9/1/200 through 11/ 30/2006. No carrier may impose a preexisting condition provisior or waiting period provision for an individual enrolling during this period (Sec. 91). - Changes requirements health benefit plans must meet with regard to premium setting and rate basis types. - Establishes maximum rate ban range from .66 to 1.32 for the following factors: age, industry participation-rate, wellness program rate, and tobacco use rate. - Carriers can apply only the following factors outside of the rating band in establishing premiums: benefit level, geographic region, rate basis type adjustment factor, and group size adjustment. - Carriers with 5,000 or more members must file a plan with the Connector to be considered

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			- Group size rate adjustment. New is .95 to 1.10. Old was .95 to 1.05. - Carriers must offer all eligible individuals and small businesses the same rate tiers that are offered to other eligible individuals or small businesses. - Carriers with 5000 or more covered lives in the small group market must offer a product through the Commonwealth Care Health Insurance Exchange. - *HC Financing Note: Reform would eliminate minimum employer contributions and minimum participation rules that can hinder a small business from offering insurance coverage.*	for the "Connector Seal of Approval." - Allows plans to offer restricted networks that differ from the overall carrier's network (66). - Establishes "Coverage for Young Adults" as a Health pla with precise specifications to b set by DOI. Premium rates to be consistent with 176J, sec. 3 (70). Individuals from 19-26 without employer-sponsored coverage are eligible. (70) - (See technical and substantive changes in sections 33 to 58).
2. **Product Flexibility/Plan Design**	- Plans may offer products with fewer mandates, but must continue to include coverage for pre-natal and maternity care, pap smears, mammograms, early intervention, **diabetes-relates services**, and outpatient mental health services. - Plans must continue to offer at least 1 product that includes all mandated benefits. - Authorizes more flexible HMO plans, which may include deductibles consistent with federal HSA law, co-insurance and/or capped outpatient benefits. - Limits on outpatient coverage deemed reasonable if: - (1) visit limit is no less than 2X average expected utilization; (2) dollar limit is no less than 4 X average expected incurred claims; and (3) mental health limit is no less than limit for certain other services. - Not available if employer offered	**Original Bill** - Assistant Secretary for Health Access will certify as qualified health plans that meet or exceed "reasonably adequate minimum standards of coverage." - "Reasonably adequate minimum standards" must include the following "medically necessary" services: Reasonably comprehensive physician services, inpatient and outpatient hospital services, emergency health services, full range of effective clinical and preventive care, and outpatient prescription drugs." Plans certified by the Secretary would be deemed "qualified" and eligible for a sliding-scale subsidy program.	- Plans offered through "Exchange" will be eligible for consideration as long as they continue to offer coverage for primary care, emergency services, surgical benefits, hospitalization, outpatient benefits, and mental health. At least 1 plan must offer prescription drug coverage. (Section 87 of new bill.) DOI must authorize any plans. - Provider network may be defined. - Exchange products cannot be required to include infertility treatment, and any other mandated benefits as determined by the Exchange board. - Exchange plans can't be required to meet any other benefit limitations or health care delivery network design in any other law.	- Directs DOI to establish and publish annually minimum standards for health insurance products. - Qualified student health insurance plans and coverage for young adult plans will not be subjected to the same minimum standards and guidelines **<u>Connector Health Plans</u>** - As originally conceived, products offered through connector must include the following categories of coverage: preventive and primary care; emergency services; surgical and hospitalization benefits; ambulatory benefits; mental health, and maternity benefits. - **House Rewrite of Connector** Plans receiving a Connector "Seal of Approval" must meet

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	subscription services in past 12 months.			all requirements of current law but would not be required to meet any other health care delivery network design in any other law; No longer has to offer a plan that includes a prescription drug benefit. New mandates would not have to apply to any health benefit plans receiving "seal of approval." (page 58H) - Plans must provide good value offer high quality. (page 58J) **Young Adult Plans** - Must provide reasonably comprehensive coverage as described in sec. 70, and may impose reasonable co-pays, co-insurance and deductibles; may only be issued through connector and at least 1 plan must have prescription drug benefit. - Premium rates must be consistent with 176J, 3.
3. Pre-existing Condition Exclusions and Waiting Periods	- Section 56A (p.89A). Provides that a carrier cannot impose a pre-existing condition exclusion or waiting period for more than 3 months following an individual's effective coverage date with respect to Trade Act/Health Coverage Tax Credit Eligible persons.		- Carriers may impose a 6 month –pre-existing condition exclusion or a 2 month waiting period on individuals without prior creditable coverage. - No waiting period for individuals insured for more than 18 months - Pregnancy is not a pre-existing condition - Emergency services must be covered during waiting period	- Carriers will have to offer coverage effective within 30 days to any eligible individual who requests coverage within 63 days of prior creditable coverage. - If 63 day period has lapsed, carriers must offer coverage to eligible individuals but may impose a 6 month exclusion fo pre-existing conditions and a 4 month waiting period for receipt of services – except emergency services which mus be covered. - Plans offered to individuals

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				without coverage for 18 month prior to application may not be subjected to a waiting period. - A carrier may deny enrollment in any plan if the carrier files proof of intent to stop selling that plan with DOI. - Certain plans (offered to trade Act/Health coverage tax credit eligible persons) may not include a waiting period of more than 3 months or a pre-existing condition exclusion. - Increased period in which eligible individual may go without coverage from 30 days to 63 days before a pre-existing condition may be excluded from coverage. - Decreases waiting period in which a newly insured membe must wait for coverage from 6 months to 4 months. - Eliminates waiting period entirely for eligible individuals who have had no creditable coverage for the past 18 months. - Specifically defined "creditabl coverage" rather than general "coverage." - Excludes pregnancy as a pre-existing condition in section 176N.
4. Distribution Channels: Pre-Tax Purchase of Coverage by Individuals	Establishes Commonwealth Care Exchange, with authorization for "sub-exchanges". (new p.64C, sec. 34B) - Health Plan requirements – p. 64M, - Eligible small group/employer requirements – (p.64N) - Dedicates $1.5M to outreach (58F,		- Establishes the Commonwealth Care Health Insurance Exchange as an independent government authority governed by a 9-member board. - Eligible individuals and small businesses may purchase coverage through the Exchange. Defines an	- Establishes Commonwealth Health Insurance Connector within A & F with ties to GIC and governed by an 11 membe board which CANNOT includ a carrier representative. - The Connector must begin

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without an Employer Contribution	p.92) - Dedicates $4.5M for administration (58G) - Establishes the Commonwealth Care Health Insurance Exchange as an independent government authority governed by a board. - Eligible individuals and small businesses may purchase coverage through the Exchange or sub-exchange. **Eligible Individuals**: - Defines an "eligible individual" as: (1) A MA resident; and (2) If working for an employer w/ more than 50 employees, is not offered subsidized employer-sponsored coverage, or is not Medicaid or Medicare-eligible. **Eligible Small Groups (p.64D)** - sole proprietors, labor unions, and certain employers or associations up to 50 employees. **Employer Requirements (p.64N)** - Employers offering coverage through the Exchange may set their own contribution levels, if any, but cannot change them during a designated period. - The employer must participate in a payroll deduction program, enabling employee to purchase coverage on a pre-tax basis. **Health Plan Requirements (p.64M)** - Authorized by DOI Commissioner - Description of Benefits - Must include: preventive and primary care; emergency services, surgical benefits, hospitalization benefits, ambulatory benefits, pregnancy, prenatal, post-partum care, pap-smears, mammograms, early		"eligible individual" as: (1) A MA resident; and (2) If working for an employer w/ more than 50 employees ineligible for employer-sponsored coverage - Employers offering coverage through the Exchange may set their own contribution levels, irrespective of a carrier's minimum contribution requirements. - The employer must participate in a payroll deduction program, enabling employee to purchase coverage on a pre-tax basis. - (Note from earlier Romney Bill: If the carrier's minimum contribution requirements are not met, it is not clear whether the group size adjustment for nongroup members could be applied.) - Carriers may continue to enroll eligible individuals and small groups through existing distribution channels and are not required to offer direct enrollment to small groups who do not meet the carrier's participation and contribution requirements.	offering health benefit plans by October 1, 2006. - Eligible individuals and small groups may purchase coverage through the Exchange. Defines an "eligible individual" as: (1) A MA resident; and (2) is not offered subsidized health insurance by an employer with more than 50 employees. - Eligible small groups also defined. - Small group seeking to participate in Connector must stipulate to many issues, including: (1) employer determines criteria for eligibility, enrollment and participation in connector and amount of employer contributions (if any) to health plan; (2) employers will participate in payroll deductior to facilitate payment of deductible premium payments. **Health Insurance Requirements**: - Must include detailed benefits description. - Plans receiving the "connector Seal of Approval" will not be required to meet any other benefit limitations or health care delivery network design ir any other law. (Check on requirement for prescription drug benefit). - Any health benefit plan receiving the "Connector Seal of Approval" may exclude any new mandated benefit coverag implemented after January 1, 2006.

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	intervention services, and mental health services as set in 175, 47B, except for policies that limit outpatient physician services, as long as coverage for outpatient mental health is consistent with that limitation. - Can't be disapproved solely b/c it doesn't have coverage for at least 1 mandated benefit, but at least 1 plan must offer a prescription drug benefit. Can exclude, until 2008, any new mandated benefit coverage. - "Seal of Approval" for good value and above requirements. - Exchange may surcharge premiums for administrative expenses.			
5. Reinsurance: State Funded	**Establishes a Reinsurance Trust Fund** (for $15M). - Will reimburse non-group and small group carriers for 90% of annual claims costs between $100K and $500K for non-group and for 1-5; subject to annual increase in corridor. - Funded with "Free Rider" surcharge. - Expected state reimbursement must be reflected in premiums.	**Original Bill** Allows reinsurance for "qualified plans" in individual/small group – 90% of claims paid between initial attachment point and the maximum reinsured amount in a calendar year for any member. Asst. Secretary for health access determines reinsurance corridor. **Ballot Initiative** Authorizes EOHHS to implement a targeted reinsurance program to lower premiums for small business and individuals.	*HCF: Creates a reinsurance fund of $50M only for the initial use of "Safety Net Care" insurers within the Insurance Exchange.*	- No provision.
6. Reinsurance: Carrier Funded			Expands the existing small group reinsurance plan for indemnity carriers to include all carriers and to apply to the combined small-group/non-group market.	- Repeals small group reinsurance plan. - Authorizes a reinsurance plan to be established if determined necessary by the DOI Commissioner. - All carriers in 176J would be required to participate and 5 would participate in Governing Board (Section 68).

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7. Health Savings Accounts	- Provides favorable state tax treatment for HSA contributions and accumulations.		Allows HMO's to offer plans with deductibles that are consistent with federal HSA law. Assumes use of HSAs.	- Provides favorable state tax treatment. - Allows HMO's to offer plans with a "maximum deductible consistent with the maximum deductible requirements allowed for a federally-established HSA."
8. Pre-Tax Purchase of Health Insurance	Exchange, above.		Exchange would require premium payments to be taken as payroll deduction pre-tax.	Connector would require premium payments to be taken as payroll deduction pre-tax.
9. Mandated Benefits	- Moratorium on new mandated benefits until January 1, 2007, or until the Small group review board files its report with Legislature. (49) - DHCFP must study existing mandates and report to Legislature by December 1, 2006. (50)		- Products offered through the Exchange can't be required to include coverage for infertility, and any other mandated benefits that the Board allows to be excluded. - In the Exchange, Health plans may exclude, through 12/31/08 – any new mandated benefit coverage implemented after January 1, 2006.	- Moratorium on new health insurance plan mandates. - See above for product requirements offered through Connector. - New mandates would not appl to any health benefit plans receiving "seal of approval."
10. Mandated Dependent Coverage	- Requires dependent coverage to unemployed, non-student dependents up to age 25.			Requires dependent coverage up to age 25 or for 2 years past "loss of dependent status" whichever first occurs.
11. Municipal Health Insurance	- Free rider extended to municipal employees		Authorizes municipal GIC which will remove health plan design from collective bargaining (but will not be authorized to make adjustments to employer and employee premium contributions, but may change co-pays and deductibles.)	No provision.
12. State Health Insurance			- Exempts the design of any health and dental plans from collective bargaining. - Any state employees and contractors that are not eligible for GIC coverage may purchase health plans through	- Any state employees and contractors that are not eligible for GIC coverage may purchas health plans through the Connector.

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			the Exchange.	
12A. Standardized Coding and Claims	- Standardized claims and coding tied to Medicare. (Sec.33A, page 49A)			
13. Other Provisions			Eliminates prohibition on GIC from contracting with HMO's unless they participate in MassHealth or certify to a good faith effort to participate	- Study Commission on the cost of health insurance premiums before and after health reform (sec. 110). - Mandate on insurers to submit information to DOI to determine if premiums are being adjusted due to savings from Pool assessment elimination (111).
II. STATE STRUCTURAL CHANGES and the UNCOMPENSATED CARE POOL				
	Division of Insurance - Creates Deputy Commissioner for Health Care Access within DOI - Changes and moves IPP program to Dept. of Labor and Workforce Development.	**Original Proposal** Creates New Office of Health Access, led by Asst. Secretary for Health Care Access.	**Creates Commonwealth Insurance Exchange.** (See detail at end of chart).	Creates a new Health Access Bureau within DOI with responsibility for oversight of the small group and individual health insurance market and affordable health plans.
14. Free Care Pool	- Pool remains intact - Section added to require Commonwealth to fund shortfalls when payment to cost ratio for hospital or CHC falls below 95%. (39) - Pool regulations as of 9/15/2005 frozen through FY2007 (58A)	**Ballot Question** - Eliminates assessment on health plans. - Reduces hospital assessment to $80M statewide.	- Eliminates Free Care Pool - Repeals assessment on Insurers as of June 30, 2006, but replaces it with obligation to "Safety Net Care Expendable Trust." DHCFP and Exchange will determine annual amounts.	- Eliminates Free Care Pool in October. - Repeals assessment on health plans in July 1, 2006, but reinstates it up to $320 million if Employer assessment is deemed unlawful. - Transfers $410M to new "Safety Net Care Trust Fund" - the pool successor – in FY07, and requires that at least $70M

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				go to publicly operated hospitals. - Maintains hospital assessment of $160M. (check). - Moratorium on new pool regulations until October 1, 2006.
15. **Free Care Pool Successor**	**Free Rider Surcharge Program** (See below).	**Partial Successor: Ballot Question** - Affordable Health Care Fund - Massachusetts Quality Affordable Health Care Program - Uninsured individuals below 400% of poverty are eligible. - Authorizes increased eligibility and benefits to employers and employees in the IPP. - Authorizes sliding scale premiums for households below 400% of FPL, and if authorized, tax credits.	**Transition Provider Assistance Board at A & F** - Will allocate funds to hospitals and CHC's for free care - Contingent on proof of debt collection efforts and "financial distress" or hardship. - Transitional Assistance Fund will have $250M in FY07, $200M in FY08, and $100M in FY09. (Safety net insurance fund will have priority over safety net provider assistance). **Safety Net Care Expendable Trust (Sec. 94-95)** - Continues to assess hospitals and health plans $160M annually to Safety Net Care Expendable Trust for 1 year. - Thereafter, DHCFP in consultation with the Exchange will annually determine hospitals and health plan liability to SNC Trust.	**Health Safety Net Trust Fund** - Will receive $160M assessmer by hospitals. Will receive federal funds and Commonwealth Care funds to the extent that free care costs d not decline immediately. - "Health Safety Net Office" established at Medicaid - Reimbursement based on actua claims and in "fee for service" manner, tied to Medicare, including Medicare adjustment for GME, etc. (p.23A).
III. COVERAGE FOR LOW TO MODERATE INCOME POPULATIONS				
16. **Medicaid Enrollment**	$3M to enrollment efforts to capture an additional 100K+ lives. Revives "mini-grant" program.	*HCF: Supports increased funding for Medicaid outreach (but no language in bill.)* - Original bill Creates a new "Office of Health Access" and an "Assistant Secretary for Health Access" within EOHHS.	No funding but anticipates added enrollment of 106K	Amends budget line-item to require that outreach funds are targeted in areas with a high % of uninsured individuals, or limited access to providers. Funds go to a "Statewid Health Access Network System" which provides infrastructure and support for MassHealth outreach an

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				enrollment.
17. **Medicaid Expansion/Change**	Expands MassHealth as follows, effective July 1, 2006: - children to 300% of FPL - Parents to 200% of FPL - HIV-positive to 200% of FPL. - Raise enrollment in MassHealth CommonHealth by 1,600 members (54), on MassHealth HIV by 250 members (55), and on MassHealth essential by 12,000 members (56). - Funding for Legal immigrants (7K) ($10M) - Directs EOHHS to maximize SCHIP matching dollars (65%) (57). - Tobacco Cessation Pilot – coverage by MassHealth for 2 years - $7M allocated. (53) - Coverage for services covered as of 1/1/2002 (13B 4/5, page 25B). Long-Term Care: (New Section 11B) - Medicaid to establish clinical eligibility for Long-Term Care benefit – which must be given the choice of care that is least restrictive; income eligibility up to 300% of FPL - Mandated Pre-Admission counseling for Long Term Care.	**Ballot Initiative and Original bill** - Expands Medicaid coverage to adults below age 65 whose income is up to 200% of the FPL, and to children below age 21 whose income is up to 300% of FPL. (But Medicaid may require individuals to enroll in employer-based coverage if it is cost-effective.) - Requires coverage for all services that were covered as of 1/1/2002. **Original Bill** - Restores MassHealth coverage to legal immigrant adults		Expands MassHealth as follows, effective July 1, 2006: - children to 300% of FPL - Childless adults to 100% of FPL - Parents to 200% of FPL - HIV-positive to 200% of FPL. - MassHealth Essential coverage for "special status" immigrants - Raise enrollment in MassHealt CommonHealth by 1,600 members, on MassHealth HIV by 250 members, and on MassHealth essential by 12,00 members. - Directs EOHHS to maximize SCHIP matching dollars (65% -
18. **New Health Insurance Program for Low-Income Uninsured**		**Original Bill:** **Subsidized Insurance Program** - Sliding scale based on income as % of FPL for individuals under 400% of FPL, and ineligible for Medicaid. - Assistance to individuals or families enrolled in qualified plan or employer-sponsored plan. - Asst. Secretary establishes minimum employer contributions for the employer-sponsored health plans. - Not eligible if you were eligible for	**Safety Net Care Health Insurance Program** Eligibility Criteria - Exchange determines eligibility. - Must be MA resident or citizen, income is 300% of the FPL or below, and individual is not eligible for Medicaid, Medicare or other relevant public programs; - Individual cannot be a full-time or part-time student required to participate in qualifying student	**Creates Commonwealth Care Health Insurance Program.** Eligibility: (Section 29) - Connector Board bears overall responsibility, but must consul with Medicaid, providers and Medicaid MCO's. Board sets criteria for premium assistance but must include appropriate geographic distribution of providers, sliding scale premium contribution payment

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		employer-based coverage in previous 12 months. - Employee "automatically" assigned to qualified plans where employer-based coverage is unavailable.	health insurance programs; - Not eligible if the resident's employer contributes at least 20% toward premium costs for a family health insurance plan or 33% of the premium costs of an individual plan; likewise if such insurance is available through a spouse; - Not eligible if the individual has accepted a financial incentive from his employer to decline the employer's subsidized health plan. - Exchange may waive 1 and 2 above, if the employer is in compliance with certain other insurance laws, provided that the employer must then pay its premium contribution to the exchange. (Must be median health insurance premium contribution made by the employer to all its full-time employees). Employer payment will offset state subsidy first, followed by offset for employee's contribution. Premium Assistance - Only available to individuals that purchase health plans with no annual deductible and with the Comm. Care "Seal of Approval." Hospital and Health Plan Liability to Safety Net Care Expendable Trust Fund - Will be determined annually by the DHCFP in consultation with the Exchange. - Capped at $160M for FY2007 - Establishes enforcement mechanisms for collection of these liabilities. Health plans (Surcharge Payors) - May be subject to civil penalties of $5K/day for failure to fine any data or other information required by the Division. $10M to Exchange to educate and increase	schedule for enrollees, etc. (page 27A). - MA resident for 6 months, income up to 300% of FPL, ineligible for MassHealth or Medicare, - Not eligible if the resident's or family member's employer has contributed at least 20% towar premium costs for a family health insurance plan or 33% c the premium costs of an individual plan. - Not eligible if employer offers incentive to decline employer-sponsored coverage. Premium assistance - Will be made in accordance with schedule set by Connecto Board. - Only available to plans with nc annual deductible. - Secretary may cap enrollment funds run dry.

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
			awareness for uninsured. $7M from rainy day funds for administrative and operating costs.	
19. **Medicaid MCO's**	- Freeze on Behavioral Health changes or recommendations until public hearing, and in no case prior to 2/15/2006. - MCO's maintaining NCQA accreditation must be considered compliant with Medicaid for any standards measured. Still required to file contractually required reports. (58E)		- From July 1, 2006 through June 30, 2008, only Medicaid MCOs contracted with the Commonwealth as of July 1, 2006 may receive premium assistance payments from the Exchange in connection with the Safety Net Care program, - But if the MCOs do not have a combined total of safety net enrollees of the following amounts as of the following dates, then non-Medicaid managed care organizations may receive premium assistance payments: - January 30, 2007 : 100,000 lives - December 31, 2007: 120,000 lives - March 31, 2007: 142,000 lives	- From July 1, 2006 through Jun 20, 2009, only carriers that are Medicaid MCO's contracted a of July 1, 2006 may receive premium assistance payments. - Any MCO that receives payments must be licensed by DOI. - If the MCO's do not have a combined total of 40K enrolle as of 6/30/2007, and 80K enrollees as of 6/30/2008, non-Medicaid MCO's may receive premium assistance. (101) - GIC must use a methodology t analyze and adjust for variations in clinical risk amon populations served by each of the Commonwealth Care contractors. - Adjustments to final payments shall be made in accordance w the risk-adjustment methodology, but funds from the Commonwealth Care Fund may be made available for transitional supplemental rate payments for all managed care organizations that meet enrollment goals and other criteria set by the Connector Board and the Health Safety Net Office director that are designed to maximize enrollment into health insuranc of current Free Care Pool user - Prevents EOHHS from making any changes to the contracts pertaining to behavioral health

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
				prior to March 31, 2006.
20. Insurance Partnership Program	**Expands Insurance Partnership Program** - Renames the program "Health Care Plus" and transfers it to the Department of Labor and Workforce Development. - Employee eligibility > to 300% of FPL - Employer eligibility > to 75 employees - Increases employer subsidy from $400/800/1000 to $600/1200/1500.	**Ballot Question:** Authorizes expansion without including specific dollar amounts. Authorizes an increase in the maximum number of employees permitted for employer eligibility, and increase in payments to eligible employers, and an increase in the maximum employee income level permitted for eligibility. **Original Bill:** Increases eligibility for small business enrollment for companies with up to 75 employees, raise income eligibility to 250% of FPL, and increase employee subsidies by 50%. DMA would have to streamline enrollment and participation.		- Eliminates the IPP
Other MassHealth Provisions	**IGT Replacement:** - $366M in supplemental payments to qualifying providers, intended for UMass, Boston Medical Center, and Cambridge Health Alliance (Section 58N). - Supplemental payments to Cambridge and Boston consistent with FY2006. (52) **EOB Pilot** - Pilot to provide EOB to MassHealth patients after services. **EOHHS Eligibility Changes** - EOHHS changes in eligibility or services will only be allowed after public notice and a hearing. **Prior Authorization** - Establishes new provisions regarding the Medicaid prior authorization laws. Section 13A1/2 (page. 24A) **Coverage for non-emergency ambulance transport for Basic and Essential**			**Selective Networks for MassHealth** - Directs EOHHS to create a pla for selective MassHealth Provider networks, while takin into account geography and cultural competence, and repor back to the Legislature by January 1, 2007. - Requires Medicaid report on activities of Medical Care Advisory Committee. **Disability Standard** - Restricts MassHealth from establishing a disability standard that is more restrictiv than federal Social Security guidelines. **EOHHS Changes** - EOHHS must provide public notice and hearing prior to adopting regulations restrictin MassHealth benefits.

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
	enrollees - coverage up to $300K annually – by medical necessity (section 13B 1/5) **Disability Criteria** - Prohibition on disability criteria more restrictive than Medicare.			**Benefit Restoration** - Restores dental and other benefits that were cut in 2002. **Wellness Program** - Directs EOHHS to develop a "wellness program" with smoking cessation and other goals. **Coverage for non-emergency ambulance transport for Basic an Essential enrollees** - coverage up to $300K annuall – by medical necessity (sectior 13B 1/5)
21. **State-Subsidized Insurance**	IPP above.	See above.		
		IV. EMPLOYER AND INDIVIDUAL MANDATES		
22. **Employer Mandate**	**Free-Rider Assessment (p.25)** - Charged to "non-providing" employers of 51 or more employees who (1) employ individual receiving Medicaid or Free Care; and (2) DOES NOT offer coverage to the individual. - Assessment will be 100 to 150% of Free Care Claims costs incurred by uninsured employees. (original bill was 50 to 100%) + administrative surcharge to DHCFP. - First $50M deposited to Reinsurance Trust Fund. - Must sign a "Health Insurance Responsibility Disclosure" indicating whether employer offers coverage and whether employee accepted coverage or has alternative coverage. - Informs employees of possible assessment if they decline coverage. - AG enforcement - Provider notice to Pool user of	**Ballot Initiative Includes "Employer Mandate"** - Employers will be assessed "Affordable Health Care Fair Share Assessments" of 7% of adjusted payroll for firms with 101 or more employees. - 5% assessment for employers with up to 100 employees. (Adjusted payroll is annual payroll minus $50K). - Employers are provided credit against assessment equal to employer expenses for health insurance (that would be deductible under federal law). Credit cannot reduce an assessment below 0. (Non-refundable). - Administered by EOHHS in consultation with the Director of Workforce Development and DOR. - Regs may include exemptions for substantial hardship, etc.		- Beginning July 1, 2006, employers of more than 10 employees will be assessed a "Commonwealth Care Contribution." - Contribution will be phased in over 18 months starting at wages x 3% for employer of 1 to 99, and 5% for employers o 100 or more. - Eventually phased in to 5% an 7% respectively. - "Comm. Care contribution wage base" will be equal to the a federal maximum wage base, but will be 0 for employees with outside coverage. - Employers are provided credit against assessment equal to employer expenses for health insurance (including those that would NOT necessarily be

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
	criminal penalties for fraud.	- Assessments must be deposited into Affordable Health Care Fund. **Original Bill:** Includes employer assessment.		deductible under federal law). Credit cannot be reduced belov 0. (Non-refundable).
23. Individual Mandate	**Free-Rider Assessment** - "Voluntarily uninsured" employee is an individual who (1) has income over 300% of FPL, (2) is offered employer-sponsored coverage, and (3) declines coverage. - Assessment amount is 30-100% of cost of Free Care provided to the individual + administrative surcharge to DHCFP. **Individual Mandate Study** - Requires DHCFP to study mandating that all individuals obtain employer-based coverage. (37)		- As of January 1, 2007, requires MA residents over age 18 to obtain and maintain health care coverage or offer proof of financial security. (Will apply to new residents and those who terminate prior coverage within 63 days). - Defines "health care coverage" and "creditable coverage." - Proof of financial security (and payment for certain medical expenses) will be satisfied by posting a $10K bond with the Exchange, or deposit of $10K in an interest-bearing account with the Exchange; funds may only be used for payment of hospital medical claims. - Individuals who comply or end MA residency may apply for return of the funds within 3 years. - MA filers of individual tax returns must indicate that they have health care coverage or financial security. - Failure to indicate results in forfeiture of the personal income tax exemption. - DOR must retain tax overpayments for noncompliant taxpayers, up to $10K/individual. - Judgments in favor of hospitals against non-complying individuals must allow for wage attachment. - DOR to promulgate regulations to effectuate new law	- As of January 1, 2007, requires individuals for whom "creditable coverage" is deemed affordable to have "creditable coverage" in place. (Sec. 8) - Individuals must include information about health insurance status on tax forms. - DOR will assess a penalty of 50% of available premium cos for each month the individual was not covered. - Driver's license renewal is prevented if penalty remains unpaid. - Hardship exemption is included. - GIC to maintain a database of residents with creditable coverage as required to meet the individual mandate. - MassHealth to send its list of covered individuals to GIC. - Commercial plans to send monthly lists to GIC.
		V. TRANSPARENCY		
24.	- Comprehensive Transparency		- Adopts much of MAHP's	- Establishes a MA Health Care

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
Transparency	Initiative enabling legislation. (4) - MAHP reviewed and will send proposed changes to Legislature.		comprehensive transparency initiative, as modified since the Travaglini bill but places responsibility at DHCFP rather than DOI.	Quality and Cost Council in EOHHS. - Includes some of MAHP's transparency initiative and establishes a Consumer Health Information website.
VI. CREDENTIALING				
25. Credentialing	Adopts MAHP/MMS/MHA Credentialing initiative. (*Check on Floor amendment)			No provision.
VII. HOSPITAL AND PROVIDER FINANCING AND OTHER PROVISIONS				
26. MassHealth Reimbursement	- Dedicates $116M annually in Stabilization funds to new Health Care Access and Investments Trust Fund. - Expenditures authorized for phased in hospital and CHC rate increases until rates are equal to Medicare and subject to Medicare annual rate increases. (38) Increment will be 10% of Medicare plus Medicare inflation. - Physician rates (40) will receive incremental increases of at least 7% plus upward adjustments in the US Medicare Economic Index. Amendment deleted requirement that payment continues until it reaches "average commercial payment" to MA physicians. - Establishes a MassHealth Payment Policy Advisory Board of 11 members. (MAHP is included). (42) - Health Care Access and Investments Trust Fund may also be used for (1) investment in CHC's, (2) Increased Medicaid Enrollment initiatives, (3) incenting providers to deliver care in	**Ballot Question** Requires MassHealth provider payments to mirror federal Medicare reimbursement for same services. **Original Bill:** - Phases in Medicaid rate increases to reach Medicare levels. - Reimbursement method in FY2008 and forward should be same as Medicare. - Advisory Board to oversee and review changes and updates. - DHCFP annual review and report on MassHealth rates paid to providers. (17)		- $80M for hospital rate increase and $10M for community health centers. - Must be contingent on EOHHS developed quality benchmarks that draw on NQF and HQA measures. - EOHHS may accept recommendation from MHCQ and Cost Council as appropriate.

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	low-cost settings, (4) encouraging safe staffing models and health care quality (including investments in IT and equipment), and (5) to address the practice of cost-shifting to providers and consumers (sic). (Sections 3 of appropriations bill).			
27. Cost-shifting to Private Payors	Requires study on cost-shifting to private payers. (Section 17)	**Original Bill:** Requires DHCFP report on rates to include "extent to which private insurance coverage prices are higher than they would be otherwise due to inadequate payments by the Commonwealth."		- Requires a DHCFP/Auditor review of adequacy of Medicaid rates. - Review must study extent to which rates charged by providers to health plans are increased due to const-shifting
28. Determination of Need	Waives DON requirements for acquisition of new technologies by hospitals, including cyberknives and PET scanners, and other technology. (10)		Changes DON laws to prohibit issuance or renewal of hospital license if the hospital owes funding to the Safety Net Care Expendable Trust fund. (prohibition currently applies if hospital owes the pool.)	
29. Ambulatory Surgery Centers (ASC's)	- Any Medicare-certified entity or provider that operates exclusively for the purpose of providing "ambulatory surgery services" as defined in section 25B, must be defined as a clinic for purposes of licensure under section 51. (9) - Deems ASC's that meet the definition of "clinic" in DPH laws, to be compliant with DPH conditions of licensure if the ASC is JCAHO (or equivalent) accredited. (Note: This may mean exemption from DON laws). ASC's must agree to participate in Medicaid, commit to providing comparable level of free care as provided by neighboring hospitals, and ensure appropriate procedures to aid patients needing ED services following an ASC service. (47)			

HEALTH CARE REFORM
COMPARISON CHART
*** Draft ***

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
30. Malpractice Liability	Good Samaritan exemption. (11)			
31. Teaching Hospital Resident Staffing	Hospitals must submit detailed safe staffing plans for interns residents and fellows, prior to receiving increased Medicaid rates. Establishes advisory committee on working conditions of resident-physicians.			
VIII. FUNDING				
32. Funding and Expenditures	**New Funding:** - Free rider assessment - $80M Creates: - **Reinsurance Trust Fund** of $50M - to be funded with "free rider" payments. Includes Advisory Board to make recommendations on assessment levels and advice on disbursement and other issues. Pays for reinsurance program. - **Health Care Access and Investment Trust Fund**- for targeted Medicaid investments to encourage enrollment, provided incentives for care in low-cost settings, encourage safety and technology investment, and address "cost-shifting". Annual transfer of $116M from stabilization fund. **Additional Expenditures and Funding:** - Transparency: $2M - Mandate Study: $100K - Study on Ind. Mandate: $100K - IPP Reform: $20M - Tax Deduction for HSA: 1,8M - Medicaid/Provider Payments: $90M - Medicaid Physician payments: $16M - Medicaid Enrollment: $3M - Public Health Funding: $25M	**Ballot Initiative** New Affordable Health Care Fund that includes: - Cigarette tax increase of 60 cents. - Employer assessment. - Free Care Pool funds, if appropriated. - Federal Reimbursement. - Co-Pays and Fees collected pursuant to any new programs. - Investment income **Original Bill:** Similar to above, but called the Health Access and Affordability Fund. Cigarette tax was initially only increased by .50 cents.	- **Health Plan and Hospital Assessment to Pool** redirected to Safety Net Care Expendable Trust. (eligible for federal match). - Exchange may apply a surcharge on health plans for administrative and operational expenses. - Creates: - **Medical Escrow Account Fund** – A & F. Includes amounts withheld from taxpayers and the interest; retained by fund on behalf of taxpayer. expendable trust not subject to further appropriation. - **Safety Net Care Expendable Trust Fund** – A & F. Amounts paid by hospitals and surcharge payors (health plans), and FFP on safety net care payments, etc. *Safety Net Care Health Insurance Program funding will have priority over Safety Net Transitional Assistance fund.* - **Safety Net Transitional Assistance Trust Fund** – A & F. For assistance to acute hospitals and CHCs. Will have $250M in FY07, $200M in FY08, and $100M in FY09. - **Medical Assistance Trust Fund** –	- Establishes: 1) **Commonwealth Care Fund** – to receive money from employer assessment. For subsidized health insurance premiums for low-income residents, and MassHealth expansion to childless adults. Funds may be transferred to new "Safety Net Care Trust Fund" to reimburse hospitals for free care. 2) **Safety Net Care Trust Fund** - For hospitals and CHC free car payments.

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			EOHHS. Will include funds from public entities and federal reimbursements from medical assistance payments funded by the funds. Amounts in excess of medical assistance payments will be credited to General Fund. - **Department of Mental Retardation Trust Fund.** – EOHHS. Receipts from assessment per bed day for ICF/MR and community-based residences. (118G, 27), and FFP. - **$10M in Stabilization funds to Exchange for Marketing** - $7M in Stabilization Funds to Administration and Operation of Exchange.	
33. **New Health Plan Liabilities**			- Health Plan and Hospital Assessment to Pool redirected to Safety Net Care Expendable Trust. (eligible for federal match). DHCFP will determine future amounts annually in consultation with the Exchange. (Sec. 88). - Exchange may apply a surcharge on health plans for administrative and operational expenses. (87) - Health Plans must pay licensed producers commissions for Exchange enrollment. (87) - Health plans must pay labor unions, educational, professional and civic associations for the individuals they enroll in the Exchange (unless ERISA prohibits this).(87)	Connector may surcharge plans for administrative and operational expenses.
		IX. PUBLIC HEALTH		
Community Health Worker Outreach Program	- Establishes a Community Health Worker Outreach Program (8, page 13G)	**Original Bill:** - Establishes a community health worker outreach program to create		DPH to study community health outreach program and convene an advisory council to oversee study.

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
	- Funding restoration for various initiatives.	outreach plan that identifies barriers to health care, particularly in ethnic and racial minority communities, and develop strategies to reduce barriers and improve public health.\		Results by 1/1/2007.
Prevention Funds	Dedicates $25M to prevention funding.			
Public Health Council	Changes objective and composition of Public Health Council. (No gubernatorial appointees.)	**Original Bill:** - Amends Council to achieve more independence and diversity on Council. (25)		Changes composition of the Public Health Council.
		X. OTHER INITIATIVES		
Health Care Quality	- Consumer Health Care Quality and Cost Information Board (transparency) - Commission Quality and Cost Management - Allows for physician apology without liability	- Health Quality and Cost Council to develop goals to lower health care costs and improve quality of care. - Council must establish an advisory committee to represent a broad cross-section of health insurance industry.		Adopts similar proposal as HCFA.
Health Disparities	- Health Disparities Council			
Pharmacy	- Allows "Medical Peer Review Committees" in DPH to encompass a committee of a pharmacy society or association. - Allows licensed pharmacies to establish peer review committees - Establishes MA Prescription Drug Fair Pricing Program (section 18A, page 32A). - See also sections 58D and 58E - Physician and Pharmacy Manufacturer Conduct. (34A)			- Provision to return unused medications (section 107)
Miscellaneous Other Provisions	- Creation of Commonwealth Student Health Corps (7B)			- EOHHS study on CPOE and other E-Health initiatives.

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
	- Creation of Comprehensive Long Term Care Insurance Act. - Creation of Special Commission on Aging and to study Long-Term Care. (35) - Medical Residents Board - Pediatric Palliative Care Program - $5M to MA Technology Park Corporation - New Provision for Volunteer dentists (section 11C)			

APPENDIX

Romney: Individual Mandate

Adds New Law: MGL c. 111A : Individual Health Coverage.

- As of January 1, 2007, requires MA residents over age 18 to obtain and maintain health care coverage or offer proof of financial security. (Will apply to new residents and those who terminate prior
- Defines "health care coverage" and "creditable coverage."
- Proof of financial security (and payment for certain medical expenses) will be satisfied by posting a $10K bond with the Exchange, or deposit of $10K in an interest-bearing account with the Exchange hospital medical claims. Individuals who comply or end MA residency may apply for return of the funds within 3 years.
- MA filers of individual tax returns must indicate that they have health care coverage or financial security. Failure to indicate results in forfeiture of the personal income tax exemption.
- DOR must retain tax overpayments for noncompliant taxpayers, up to $10K/individual.
- Judgments in favor of hospitals against non-complying individuals must allow for wage attachment.
- DOR to promulgate regulations to effectuate new law

Romney: Commonwealth Care Health Insurance Exchange

Adds New Chapter 176Q: Commonwealth Care Health Insurance Exchange

- Creates Commonwealth Care Health Insurance Exchange to facilitate the purchase of health plans for eligible individuals and groups; delineates a comprehensive listing of powers and duties of the Exc individuals," eligible small groups," and "health benefit plans."
- Exchange may apply a surcharge on health plans to be used for administrative and operational expenses.
- Corporate is a 9 member board consisting of 4 public officials and 5 gubernatorial appointees, including an actuary, attorney specializing in employee benefit plans, and employee health benefit special representative; Chair appointed by the Governor. Board appoints an executive director.
- Participation in the Exchange by an individual or group must end if coverage is cancelled due to other insurance laws (176J, 4) that govern the circumstances under which carriers provide or deny cove
- Exchange must begin offer health benefit plans as of July 1,2006.
- Only health insurance plans that have been authorized by the Division of Insurance Commissioner and underwritten by a carrier may be offered through the Exchange.

Health Plan Requirements

- Must contain a detailed description of benefits, including maximums, limitations, exclusions and other benefit limits.
- Cannot exclude an individual based on race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.
- Must include, categorically: 1. preventive and primary care; 2 emergency services, 3. surgical benefits, 4. hospitalization benefits, 5 ambulatory patient benefits, and 6. mental health benefits.

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- Cannot be required to include:
  For policies with pregnancy-related benefits, the medically necessary expenses of diagnosis and treatment of infertility;
  Any other mandated benefits, as determined by the board;
- Cannot be required to meet any other benefit limitations or health care delivery network design in any other law.
- Carriers must offer a health benefit plan that includes a prescription drug benefit option.
- May exclude – through December 31, 2008 – any new mandated benefit coverage implemented after January 1, 2006.
- Commonwealth Care Seal of Approval must be assigned to health benefit plans that the board determines meet the above requirements; provide good value to the consumer; and are offered through the

Requirements for Participation in the Exchange by Eligible Small Groups

- Enter binding agreement with Exchange
- Employer must not offer to eligible individuals to participate in the Exchange and separate or competing group health plan offering the same, or substantially the same benefits provided through the Ex
- Employer has right to determine criteria for eligibility, enrollment and participation in the Exchange, and the amount of any employer contributions; for the term of the Agreement with the Exchange, t criteria or contribution amounts other than during a period designated by the Exchange.
- Employers must participate in a payroll deduction program to facilitate payment of health benefit premium payments by employees to benefit from favorable federal tax treatment for this approach (26
- Employer must provide information to Exchange to allow the Exchange to: 1. verify employer complies with state and federal law relative to non-discrimination; and 2. verify the eligibility of individu

Safety Net Care Provisions

- Premium Assistance payments must begin on July 1, 2006 for carriers providing health plans to Safety Net Care enrollees;
- Exchange must contract with DOR to verify income data for Safety Net Care participants.

Non-GIC Eligible State Employees and Contractors

- GIC and Exchange contract to allow these employees to purchase a health plan through the Exchange. GIC must develop protocol for making pro-rated (sic) contributions to the chosen plan on the Co

Producers

- Health plans must pay licensed producers a commission determined by the board for individual or group enrollment in the Exchange.

Labor Unions and other Associations

- Authorizes labor unions, educational, professional, civic, trade, church, non-profit, or social organizations to enroll its individual eligible members (or the individuals belonging to its member organizat Exchange.
- The organizations must be paid by the health plans, in an amount determined by the board, for persons enrolled, unless ERISA prohibits this.

Other Provisions

- Carriers participating in the Exchange must furnish reasonable reports as the board determines necessary.
- Health benefit plans may be withdrawn only after notice to the carrier.

Consumer Health Information Internet Website (Substantially similar to Travaglini Proposal)**

Exchange must establish and maintain the website, and it must be accessible by January 1, 2006.

Romney: Safety Net Care

Adds New Chapter 176R: Safety Net Care Health Insurance Program

Eligibility Criteria

- Exchange determines eligibility.
- Must be MA resident or citizen, and must be eligible if income is 300% of the FPL or below and the individual is not eligible for Medicaid, Medicare or other relevant public programs; and
  1. Individual cannot be a full-time or part-time student required to participate in qualifying student health insurance programs;
  2. Not eligible if the resident's employer contributes at least 20% toward premium costs for a family health insurance plan or 33% of the premium costs of an individual plan; likewise if such insu
  3. Not eligible if the individual has accepted a financial incentive from his employer to decline the employer's subsidized health plan.
- Exchange may waive 1 and 2 above, if the employer is in compliance with certain other insurance laws, provided that the employer must then pay its premium contribution to the exchange. (Must be n made by the employer to all its full-time employees) . Employer payment will offset state subsidy first, followed by offset for employee's contribution.

EALTH CARE REFORM
COMPARISON CHART
** *Draft* **

ISSUE	SENATE	HEALTH CARE FOR ALL	GOVERNOR ROMNEY	HOUSE
Premium Assistance - Only available to individuals that purchase health plans with no annual deductible and with the Comm. Care "Seal of Approval." **Hospital and Health Plan Liability to Safety Net Care Expendable Trust Fund** - Will be determined annually by the DHCFP in consultation with the Exchange. - Capped at $160M for FY2007 - Establishes enforcement mechanisms for collection of these liabilities. - Health plans (Surcharge Payors) may be subject to civil penalties of $5K/day for failure to fine any data or other information required by the Division.				

- ***Individual Mandate (R, AO)***

SECTION 8. The General Laws are hereby amended by inserting after chapter 111L the following chapter:-

CHAPTER 111M
INDIVIDUAL HEALTH COVERAGE

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Creditable coverage", coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another individual's plan with no lapse of coverage for more than 63 days: (a) a group or nongroup health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults pursuant to section 10 of chapter 176J or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

Comment [RLW1]: (l) A nongroup health plan, or *<depending on merger/nonmerger>*

"Resident", a person who has

(1) obtained an exemption pursuant to clause Seventeenth, Seventeenth C, Seventeenth C ½, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty-first C, Forty-second or Forty-third of section 5 of chapter 59;

(2) obtained an exemption pursuant to section 5C of said chapter 59;

(3) filed a Massachusetts resident income tax return pursuant to chapter 62;

(4) obtained a rental deduction pursuant to subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;

(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;

(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;

(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent for whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;
(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;
(10) has a child or dependent of whom he has custody who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;
(11) is registered to vote in the commonwealth;
(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or
(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

Section 2. (a) As of January 1, 2007, the following individuals over the age of 18 shall obtain and maintain creditable coverage: (1) residents of the commonwealth, or (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, provided that creditable coverage is deemed affordable for the individual according to the schedule set by the board of the connector. ~~and (3) individuals~~Residents who within 63 days have terminated any prior creditable coverage, shall obtain and maintain creditable coverage within 63 days of such termination.~~provided that creditable coverage is deemed affordable for the individual according to the schedule set by the board of the connector.~~

(b) Every person who files an individual income tax return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person had creditable coverage in force for each of the twelve months of the taxable year for which the return is filed as required under paragraph (a) whether on an individual policy or as a named beneficiary of a multi-person policy. If the person fails to indicate or indicates that he did not have such coverage in force, then a penalty shall be assessed on the return. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall assess the penalty.

(c) If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (e); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium amount which meets the definitions of creditable coverage for which the individual would have qualified for each of the months he did not meet the requirement of paragraph (a); and provided further that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in subsections (i) to (vii), inclusive, of section 13 of chapter 62D. In the case of the amount retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of the balance due on the penalty and related interest.
~~(d) which deals with RMV and non-renewal of license has been deleted.~~

(d) The commissioner shall deposit all penalties collected into the commonwealth care fund, established by section 2000 of chapter 29.

~~———~~Section 3. (a) An individual ~~deemed~~ subject to the provisions of Section 2, who disputes the determination of affordability as enforced by the department of revenue, may seek a review of this determination by a review panel established by the department of revenue. The commissioner is authorized to promulgate regulations as needed to carry out the exemption review process provided, however, that no penalties shall be enforced against an individual seeking review until the review is complete and any subsequent appeals are exhausted.

(b) An individual ~~deemed~~ subject to the provisions of section 2 may seek an exemption from these provisions if imposition of the penalty would create extreme hardship. Criteria for said hardship exemption shall be determined by the commissioner.

Section 4. The commissioner of revenue, in consultation with the board of the commonwealth health insurance connector established by Chapter 176Q, shall promulgate such rules and regulations, as necessary, to carry out the purposes of this chapter~~.~~, taking into account factors including, but not limited to, definition of creditable coverage; appeals review process, including hardship exemptions; and applications of non-coverage penalties including reductions for grace periods.

- ***Individual Mandate (R, AO)***

SECTION 8. The General Laws are hereby amended by inserting after chapter 111L the following chapter:-

CHAPTER 111M
INDIVIDUAL HEALTH COVERAGE

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Creditable coverage", coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another's plan with no lapse of coverage for more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults pursuant to section 10 of chapter 176J or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

"Resident", a person who has

(1) obtained an exemption pursuant to clause Seventeenth, Seventeenth C, Seventeenth C ½, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty-first C, Forty-second or Forty-third of section 5 of chapter 59;
(2) obtained an exemption pursuant to section 5C of said chapter 59;
(3) filed a Massachusetts resident income tax return pursuant to chapter 62;
(4) obtained a rental deduction pursuant to subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;
(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;
(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;
(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent for whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;
(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;
(10) has a child or dependent of whom he has custody who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;
(11) is registered to vote in the commonwealth;
(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or
(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

Section 2. (a) As of January 1, 2007, the following individuals over the age of 18 shall obtain and maintain health care coverage: (1) residents of the commonwealth, (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, and (3) individuals who within 63 days have terminated any prior creditable coverage, provided that creditable coverage is deemed affordable for the individual according to the schedule set by the board of the connector.

(b) Every person who files an individual return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person had health care coverage in force for each of the twelve months of the taxable year for which the return is filed as required under paragraph (a) whether on an individual policy or as a named beneficiary of a multi-person policy. If the person fails to indicate or indicates that he did not have such coverage in force, then a penalty shall be assessed on the return. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall assess the penalty.

(c) If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (e); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium amount which meets the definitions of creditable coverage for which the individual would have qualified for each of the months he did not meet the requirement of paragraph (a); and provided further that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in subsections (i) to (vii), inclusive, of section 13 of chapter 62D. In the case of the amount retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of the balance due on the penalty and related interest.
(d) which deals with RMV and non-renewal of license has been deleted.

(d) The commissioner shall deposit all penalties collected into the commonwealth care fund, established by section *2000* of chapter 29.

Section 3. (a) An individual deemed subject to the provisions of Section 2, who disputes the determination of affordability as enforced by the department of revenue, may seek a review of this determination by a review panel established by the department of revenue. The commissioner is authorized to promulgate regulations as needed to carry out the exemption review process provided, however, that no penalties shall be collected from an individual seeking review until the review is complete.

(b) An individual deemed subject to the provisions of section 2 may seek an exemption from these provisions if imposition of the penalty would create extreme hardship. Criteria for said hardship exemption shall be determined by the commissioner.

Section 4. The commissioner of revenue, in consultation with the board of the commonwealth health insurance connector established by Chapter 176Q, shall promulgate such rules and regulations, as necessary, to carry out the purposes of this chapter, taking into account factors including, but not limited to, definition of creditable coverage; appeals review process, including hardship exemptions; and applications of non-coverage penalties including reductions for grace periods.

Senate, No. 2282
Text of the Senate amendments to the House Bill promoting access to health care.
11/16/05 S Ways and Means new text for S2276
11/16/05 S See H4479 -SJs 1280-1286

House, No. 4479
Bill promoting access to affordable, quality, accountable health care.
11/03/05 H House, No. 4463 printed as amended
11/03/05 H Passed to be engrossed - 131 YEAS to 22 NAYS (See Yea and Nay in Supplement, No. 271)
11/03/05 H Motion to reconsider negatived -HJ 896
11/07/05 S Read; and referred to the committee on SENATE WAYS AND MEANS -SJ 1084
11/08/05 S Reported (in part) by S2265 -SJ 1090
11/08/05 S Committee recommended residue out to pass with an amendment, S2266 -SJ 1090
11/09/05 S Order relative to subject adopted -SJs 1090-1091
11/09/05 S Read second
11/09/05 S For Senate actions to Ways and Means proposed new text, see S2266
11/09/05 S Amended by striking out all after the enacting clause and inserting in place thereof the text of S2276, printed as amended
11/09/05 S Ordered to a third reading
11/09/05 S Read third
11/09/05 S Passed to be engrossed - 38 YEAS to 0 NAYS (see Senate Roll Call, No. 197) -SJs 1094-1167D
11/14/05 H Rules suspended
11/14/05 H House NON-concurred in the Senate amendments
11/14/05 H Committee of conference appointed (Walrath-Mariano-Hargraves) -HJ 935
11/15/05 H Motion to reconsider committee of conference prevailed
11/15/05 H Motion to reconsider NON-concurrence of Senate amendments prevailed -HJ 951
11/16/05 S Motion to reconsider engrossment prevailed
11/16/05 S Ways and Means new text, S2282 adopted
11/16/05 S Passed to be engrossed -SJs 1280-1286
11/16/05 H Rules suspended
11/16/05 H House NON-concurred
11/16/05 H Committee of conference appointed (Walrath-Mariano-Hargraves) -HJs 958-959
11/16/05 S Senate insisted on its amendments
11/16/05 S Committee of conference appointed (Moore-Murray-Lees), in concurrence -SJ 1296
04/03/06 H Reported by committee of conference
04/03/06 H For report, see H4850
04/03/06 H Placed in the Orders of the Day for the next sitting, the question being on acceptance
04/04/06 H Committee of Conference report accepted - 154 YEAS to 2 NAYS (See Yea and Nay in Supplement, No. 368)
04/04/06 S Committee of conference report accepted - 37 YEAS to 0 NAYS (see Senate Roll Call, No. 241) -SJs 1636-1637
04/04/06 H Emergency preamble adopted -HJ 1364
04/04/06 S Emergency preamble adopted -SJ 1641
04/04/06 H Enacted - 155 YEAS to 2 NAYS (See Yea and Nay in Supplement, No. 370) -HJ 1364
04/04/06 S Enacted -SJ 1641
04/05/06 S Laid before the Governor -SJ 1642

04/12/06 G Signed (in part) by the Governor, Chapter 58 of the Acts of 2006
04/12/06 H Governor returned sections 5, 27, 29, 47, 112, 113, 134 and 137
04/13/06 H For message, see H4857 -HJ 1384
04/13/06 H Referred to the committee on HOUSE WAYS AND MEANS
04/25/06 H Veto of Section 29 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 29, passed over veto - 147 YEAS to 10 NAYS (See Yea and Nay in Supplement, No. 389)
05/04/06 S Section 29, passed over veto - 37 YEAS to 2 NAYS (see Senate Roll Call, No. 244) -SJs 1696-1697
04/25/06 H Veto of Section 113 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 113, passed over veto - 140 YEAS to 18 NAYS (See Yea and Nay in Supplement, No. 390)
05/04/06 S Section 113, passed over veto - 33 YEAS to 5 NAYS (see Senate Roll Call, No. 246) -SJs 1700-1701
04/25/06 H Veto of Section 47 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 47, passed over veto - 137 YEAS to 20 NAYS (See Yea and Nay in Supplement, No. 391)
05/04/06 S Section 47, passed over veto - 31 YEAS to 9 NAYS (see Senate Roll Call, No. 245) -SJs 1697-1699
04/25/06 H Veto of Section 134 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 134, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 392)
05/04/06 S Section 134, passed over veto - 32 YEAS to 7 NAYS (see Senate Roll Call, No. 247) -SJ 1702
04/25/06 H Veto of Section 112 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 112, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 396)
05/04/06 S Section 112, Motion to lay on the table pending and postoned to the next session -SJs 1699-1700
05/11/06 S Section 112, postponed to Thursday, May 18 -SJs 1727-1728
06/01/06 S Section 112, postponed to Thursday, June 15 -SJ 2094
06/15/06 S Motion to lay on the table negatived
06/15/06 S Section 112, passed over veto - 37 YEAS to 0 NAYS (see Senate Roll Call, No. 291) -SJs 2154-2155
04/25/06 H Veto of Section 5 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 5, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 397)
05/04/06 S Section 5, passed over veto - 33 YEAS to 6 NAYS (see Senate Roll Call, No. 243) -SJs 1693-1695
04/25/06 H Veto of Section 137 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 137, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 398)
05/04/06 S Section 137, passed over veto - 33 YEAS to 6 NAYS (see

04/25/06 H Veto of Section 27 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 27, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 398)
05/04/06 S Section 27, Motion to laid on the table pending and postponed to the next session -SJs 1695-1696
05/11/06 S Section 27, postponed to Thursday, May 18 -SJ 1727
05/24/06 S Section 27, passed over veto - 34 YEAS to 5 NAYS (see Senate Roll Call, No. 266) -SJs 1774-1775

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Bill promoting access to affordable, quality, accountable health care.
11/03/05 H House, No. 4463 printed as amended
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11/16/05 S Passed to be engrossed -SJs 1280-1286
11/16/05 H Rules suspended
11/16/05 H House NON-concurred
11/16/05 H Committee of conference appointed (Walrath-Mariano-Hargraves) -HJs 958-959
11/16/05 S Senate insisted on its amendments
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04/25/06 H Rules suspended
04/25/06 H Section 29, passed over veto - 147 YEAS to 10 NAYS (See Yea and Nay in Supplement, No. 389)
05/04/06 S Section 29, passed over veto - 37 YEAS to 2 NAYS (see Senate Roll Call, No. 244) -SJs 1696-1697
04/25/06 H Veto of Section 113 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 113, passed over veto - 140 YEAS to 18 NAYS (See Yea and Nay in Supplement, No. 390)
05/04/06 S Section 113, passed over veto - 33 YEAS to 5 NAYS (see Senate Roll Call, No. 246) -SJs 1700-1701
04/25/06 H Veto of Section 47 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 47, passed over veto - 137 YEAS to 20 NAYS (See Yea and Nay in Supplement, No. 391)
05/04/06 S Section 47, passed over veto - 31 YEAS to 9 NAYS (see Senate Roll Call, No. 245) -SJs 1697-1699
04/25/06 H Veto of Section 134 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 134, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 392)
05/04/06 S Section 134, passed over veto - 32 YEAS to 7 NAYS (see Senate Roll Call, No. 247) -SJ 1702
04/25/06 H Veto of Section 112 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 112, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 396)
05/04/06 S Section 112, Motion to lay on the table pending and postoned to the next session -SJs 1699-1700
05/11/06 S Section 112, postponed to Thursday, May 18 -SJs 1727-1728
06/01/06 S Section 112, postponed to Thursday, June 15 -SJ 2094
06/15/06 S Motion to lay on the table negatived
06/15/06 S Section 112, passed over veto - 37 YEAS to 0 NAYS (see Senate Roll Call, No. 291) -SJs 2154-2155
04/25/06 H Veto of Section 5 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 5, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 397)
05/04/06 S Section 5, passed over veto - 33 YEAS to 6 NAYS (see Senate Roll Call, No. 243) -SJs 1693-1695
04/25/06 H Veto of Section 137 reported from the committee on HOUSE

04/25/06 H Rules suspended
04/25/06 H Section 137, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 398)
05/04/06 S Section 137, passed over veto - 33 YEAS to 6 NAYS (see Senate Roll Call, No. 248) -SJs 1702-1703
04/25/06 H Veto of Section 27 reported from the committee on HOUSE WAYS AND MEANS
04/25/06 H Rules suspended
04/25/06 H Section 27, passed over veto - 137 YEAS to 19 NAYS (See Yea and Nay in Supplement, No. 398)
05/04/06 S Section 27, Motion to laid on the table pending and postponed to the next session -SJs 1695-1696
05/11/06 S Section 27, postponed to Thursday, May 18 -SJ 1727
05/24/06 S Section 27, passed over veto - 34 YEAS to 5 NAYS (see Senate Roll Call, No. 266) -SJs 1774-1775