SENATE, No. 2282

Text of the Senate amendments (Senate No. 2276, as amended) to the House Bill (House, No. 4479) promoting access to health care.

The Commonwealth of Massachusetts

In the Year Two Thousand and Five.

SECTION 1. The general court finds that:

(a) The most recent analysis by the Blue Cross Foundation/ Urban Institute "Road Map Project" estimates that the number of uninsured in Massachusetts is 532,376. Of this number 73 per cent are working and 72.8 per cent are below 400 per cent of the federal poverty guidelines.

(b) The Institute of Medicine of the National Academies of Science estimate that lack of health insurance reduces life span leading to 18,000 premature deaths a year in the United States including residents of the commonwealth, because of health conditions exacerbated by lack of access to care by the uninsured, and affects the productivity of Americans with serious health conditions.

(c) The commonwealth already expends over $1.1 billion in uncompensated care through the Free Care Pool at the expense of taxpayers and the economy in the form of higher health care premiums and workforce productivity.

(d) Rapidly rising health care costs and health insurance premiums are harming the economic vitality of the commonwealth and its employers, making it difficult for employees and municipalities to pay for their share of health insurance costs, threatening to reverse the progress made in the commonwealth of reducing the number of the uninsured.

(e) Extending coverage to the uninsured in the commonwealth could result in economic and social

benefits due to improved health of as much as $1.2 to $1.7 billion per year. These benefits are estimated to exceed the incremental cost of expanding coverage by as much as a ratio of 3:1. Other economic and social benefits of covering the uninsured include:

(1) reduced incidence of personal bankruptcies — more than one half of all personal bankruptcies are directly correlated to unpaid health care expenses;

(2) minimized cost shifting of higher premiums to consumers and appropriate use of low-cost medical settings;

(3) lower payments toward taxpayer funded programs due to better health outcomes and improved health of underserved and low-income population; and

(4) improved workforce productivity.

SECTION 1A. To provide for supplementing certain items in the general appropriation act and other appropriation acts for fiscal year 2006, the sums set forth in section 2 are hereby appropriated from the Health Care Access and Investments Trust Fund unless specifically designated otherwise in this act or in those appropriation acts, for the several purposes and subject to the conditions specified in this act or in those appropriation acts and subject to the laws regulating the disbursement of public funds for the fiscal year ending June 30, 2006. These sums shall be in addition to any amounts previously appropriated and made available for the purposes of these items. Funds appropriated in this section shall not revert and shall be available for expenditure until June 30, 2006.

SECTION 2.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES.

Office of the Secretory.

4000-0352..3,000,000

Massachusetts Rehabilitation Commission.

4120-6000..1,500,000

Department of Public Health.

4510-0600..500,000

4513-1026..1,000,000

4513-1112..1,000,000

4513-11
14..1,250,000

4513-1115..500,000

4513-1121..300,000

4530-9000..1,500,000

4570-1500..5,500,000

4590-0300..6,000,000

SECTION 2A. To provide for certain unanticipated obligations of the commonwealth; to provide for alterations of purposes for current appropriations and to meet certain requirements of law, the sums set forth in this section are hereby appropriated from the Health Care Access and Investments Trust Fund unless specifically designated otherwise in this section, for the several purposes and subject to the conditions specified in this section, and subject to the laws regulating the disbursement of public funds for the fiscal year ending June 30, 2006. These sums shall be in addition to any amounts previously appropriated and made available for the purposes of these items. Funds appropriated in this section shall not revert and shall be available for expenditure until June 30, 2006.

EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE.

Reserves.

1599-0041 For the special commission studying end of life care services established in section 480 of chapter 159 of the acts of 2000..............50,000

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES.

Office of the Secretary.

4000-0140 For the operation of the Betsy Lehman center for patient safety and medical error reduction

established in section 16E of chapter 6A of the General

Laws...500,000

4000-0301 For the costs of MassHealth provider and member audit and utilization review activities including, but not limited to, eligibility verification, disability evaluations, provider financial and clinical audits and other initiatives intended to enhance program integrity; provided, that $150,000 shall be expended for the operation of the Medicaid fraud control unit within the office of the attorney general; and provided further, that $150,000 shall be expended for MassHealth auditing within the office of the state

auditor...1,500,000

Department of Public Health.

4513-1111 For an osteoporosis education and prevention program; provided, that the program shall include, but not be limited to: (1) development or identification of educational materials to promote public awareness of the cause of osteoporosis, options for prevention and the value of early detection and possible treatments, including their benefits and risks, to be made available to consumers, particularly targeted to high risk groups; (2) development or identification of professional education programs for health care providers; (3) development and maintenance of a list of current providers of specialized services for the prevention and treatment of osteoporosis; and (4) a program for awareness, prevention and treatment of hip fractures.........................175,000

4513-1116 For a renal disease program; provided, that not less than $250,000 shall be expended for renal disease programs administered by the National Kidney Foundation of Massachusetts, Rhode Island, Vermont and New Hampshire, including organ donor awareness, nutritional supplements and early intervention services for those affected with renal disease and those at risk of renal disease.........................250,000

4515-1113 For a bladder cancer screening, education and treatment program; provided, that no funds shall be expended in the AA object class for any personnel-related

costs...500,000

4515-1114 For an ovarian cancer screening, education and treatment program; provided, that no funds shall be expended in the AA
object class for any personnel-related costs....................................500,000

4516-0264 For a diabetes screening and outreach program to raise public awareness and provide outreach and education for high risk individuals, including, but not limited to, targeted populations of adolescents and the elderly..500,000

4570-1501 For the funding of a pilot cooperative agreement with Seven Hills Foundation and UMASS Memorial Health Center for the development of a residential intermediate care facility to serve the needs of Massachusetts veterans, including members of the Massachusetts National Guard, Armed Forces of the United States or Reserves who served during Operation Iraqi Freedom, Operation Enduring Freedom and Combined Forces Command —Afghanistan, with traumatic head injuries received on active duty; provided, that every effort shall be made to secure resources and financial support from the United States Veterans Administration or other federal agencies and from third party sources including, but not limited to, Medicaid; and provided further, that the Institute of Commonwealth Medicine at the University of Massachusetts Medical School shall receive funding from this appropria tion to evaluate the success of the pilot
project..1,500,000

4570-1502 For the purposes of implementing a proactive statewide infection prevention and control program; provided, that notwithstanding any general or special law to the contrary, the department of public health shall, through its division of health care quality, develop a proactive statewide infection prevention and control program in licensed health care facilities following protocols of the Centers for Disease Control for the purposes of implementation and adherence to infection control practices that are the keys to preventing the transmission of infectious diseases, including respiratory diseases spread by droplet or airborne routes; provided further, that recommended infection control practices shall include, but not be limited to, hand hygiene; standard precautions and transmission-based precautions, including contact, droplet and airborne, and respiratory hygiene; and provided further, that the infection prevention

and control program shall include mandatory education in the recommended infection control practices for licensed health care personnel and employees of licensed health care facilities and penalties for individual and institutional noncompliance with Centers for Disease Control protocols.......................................1,000,000

4590-1503 For the pediatric palliative care program established in section 24K of chapter 111 of the General Laws........................950,000

EXECUTIVE OFFICE OF ECONOMIC DEVELOPMENT.

Department of Labor.

7002-0900 For the cost of health insurance premium subsidies paid to employees of small businesses participating in the insurance reimbursement program pursuant to section 9C of chapter 118E of the General Laws; provided, that said program shall be administered by the director of labor, in collaboration with the executive office of health and human services; provided further, that all federal reimbursements received for expenditures from this item pursuant to the provisions of Title XIX and Title XXI of the federal Social Security Act shall be credited to the Children's and Seniors' Health Care Assistance Fund; and provided further, that expenditures made for the purposes of this item shall not exceed the amount appropriated in this item 10,000,000

7002-0901 For the cost of health insurance subsidies paid to employers participating in the insurance reimbursement program under section 9C of chapter 118E of the General Laws; provided, that the director of labor, in collaboration with the executive office of health and human services, shall administer the program and shall directly market the program to small business and private human service providers that deliver human and social services under contract with departments within the executive office of health and human services and the executive office of elder affairs for the purpose of mitigating health insurance costs to the employers and their employees; provided further, that the director of labor, in collaboration with the executive office, shall report quarterly to the house and senate committees on ways and means and the executive office of administration and finance, monthly expenditure data for the program, including the total number of employers participating in the program,

the percentage of the employers who purchased health insurance for employees prior to participating in the program and the total monthly expenditures delineated by payments to small employers and self-employed persons for individual, 2-person family and family subsidies; provided further, that the executive office of health and human services shall seek federal reimbursement for the payments to employers; and provided further, that all federal reimbursements received for expenditures from this item, under Title XIX and Title XXI of the federal Social Security Act shall be credited to the Children's and Seniors' Health Care Assistance Fund...10,000,000

Division of Insurance.

7006-0201 For the funding of the consumer health care costs information board, pursuant to chapter 28B of the General Laws.................2,000,000

7006-0202 For the purposes of funding an economic study of health care mandates in Massachusetts; provided, that said study shall analyze the cost impact of any and all health care mandates to the health care system and individual premiums; provided further, that said study shall analyze the cost impact and economic effect of implementing an individual mandate in Massachusetts...100,000";

SECTION 3. Chapter 3 of the General Laws is hereby amended by striking out section 38C, as appearing in the 2004 Official Edition, and inserting in place thereof, the following section:—
Section 38C. For the purposes of this section. a mandated health benefit proposal shall be one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of 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 organized under chapter 32A, individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health

maintenance organization organized under chapter 176G, an organization entering into a preferred provider arrangement under chapter 176I, and any health plan issued, renewed or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for the natural person and his dependent, including the person's spouse organized under chapter 176M.

SECTION 3A. (a) Chapter 17 of the General Laws is hereby amended by striking out section 3, as so appearing, and inserting in place thereof the following section:—

Section 3. There shall be a public health council to advise the commissioner of public health at the request of the commissioner and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 20 members appointed for terms of 6 years in accordance with this section. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

Three of the appointed members shall be the chancellor of the University of Massachusetts Medical School or his designee; the dean of the Harvard University School of Public Health or his designee; and the dean of the Boston University School of Public Health or his designee. Six of the appointed members shall be providers of health services, 1 of whom shall be the chief executive officer of an acute care hospital appointed by the Massachusetts Hospital Association, 1 of whom shall be the chief executive officer of a skilled nursing facility appointed by the Massachusetts Extended Care Federation, 1 of whom shall be a nurse executive appointed by the Massachusetts Organization of Nurse Executives, 1 of whom shall be a registered nurse chosen by the board of registration of nurses who shall be the highest vote-getter on a mail ballot sent to the address of record of all registered nurses licensed by the board of registration of nurses, and 2 of whom shall be physicians appointed by the Massachusetts Medical Society. Ten of the appointed members shall be non-providers, 1 of whom shall be appointed by the secretary of elder affairs, 1 of whom shall be appointed by the secretary of veterans' services, 1 of whom shall be appointed by Health Care For All, Inc.; 1 of whom shall be appointed by the Coalition for the Prevention of Medical Errors, Inc.; 1 of whom shall be appointed by the Massachusetts Chapter

of the National Association of Insurance and Financial Advisors; 1 of whom shall be appointed by the Massachusetts Association of Health Underwriters; and 1 of whom shall be appointed by the Massachusetts Public Health Association and 2 of whom shall be appointed from the Massachusetts health disparities council created pursuant to section ___ of chapter ___ of the acts of 2005 and 1 of whom shall be appointed by the Massachusetts Community Health Worker Network.

(b) For the purposes of this section "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest, who, and whose spouse, parents, siblings or children, has no financial interest in a health care facility, who, and whose spouse. has no employment relationship to a health care facility, to a nonprofit service corporation established in accordance with chapters 176A to 176E, inclusive, nor to a corporation authorized to insure the health of individuals, and who, and whose spouse, is not licensed to practice medicine.

(c) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The council shall meet at least once a month, and at such other times as it determines by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 a day while in conference, and their necessary traveling expenses while in the performance of their official duties.

SECTION 3A. Section 35M of chapter 10 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 10 and 11, the words:— "and administration; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund." and inserting in place thereof the following words:— ", administration and the statutory and regulatory responsibilities of the board including patient protection, physician education and health care quality improvement."

SECTION 3B. Section 35M of chapter 10 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 10 and 11, the following phrase:— "; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund".

SECTION 3C. Section 7 of chapter 26 of the General Laws, as so appearing, is hereby amended by

striking out the first sentence and inserting in place thereof the following sentence:— The commissioner of insurance may appoint and remove, with the approval of the governor, a first deputy commissioner for health care access, an actuary, a research analyst, a chief examiner and such additional deputies, examiners, assistant actuaries and inspectors as the commissioner may require.

SECTION 3D. Said chapter 26 is hereby further amended by inserting after section 7 the following section:—

Section 7A. There shall be a deputy commissioner for health care access whose duties shall include, subject to the direction of the commissioner, administration of the division's statutory and regulatory authority for oversight of the small group and non-group health insurance markets, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers relative to health insurance coverage and access to affordable products.

SECTION 4. The General Laws are hereby further amended by inserting after chapter 28A the following chapter:—

CHAPTER 28B.

CONSUMER HEALTH CARE COSTS

INFORMATION BOARD.

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

"Board", the consumer health care costs information board established in section 2.

"Clinician", any of the following health care professionals licensed pursuant to chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist and a mental health counselor.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency.

"Health care provider", a clinician, a facility or a physician group practice.

"Insurer", a carrier authorized to transact accident and health insurance pursuant to chapter 175, a

nonprofit hospital service corporation licensed pursuant to chapter 176A, a nonprofit medical service corporation licensed pursuant to chapter 176B, a dental service corporation organized pursuant to chapter 176E, an optometric service corporation organized pursuant to chapter 176F and a health maintenance organization licensed pursuant to chapter 176G.

"Physician group practice", 2 or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

Section 2. There shall be a consumer health care costs information board. The board shall consist of the secretary of health and human services, the commissioner of insurance, the executive director of the group insurance commissioner, the chief of the public protection bureau of the office of the attorney general, a representative, of the Massachusetts Medicaid policy institute, a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, a representative of the Massachusetts Association of Health Underwriters, a representative of Healthcare For All and a private purchaser of insurance appointed by the governor. The board shall be chaired by the commissioner of insurance. The board shall make available to the public, primarily through an internet site, comparative information on the cost and quality of health care services and that recognizes and makes adjustments for socioeconomic demographic data.

Section 3. (a) The board shall establish and maintain a consumer health information internet site. The website shall contain information comparing the cost and quality of health care services and that recognizes and makes adjustments for socioeconomic demographic data and may also contain general information related to health care as the board determines to be appropriate.

The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices between health care providers. Information shall be presented in a format that is understandable to the average consumer. The board shall take appropriate action to publicize the availability of its internet site and make available written documentation available upon request and as necessary.

(b) Not later than January 1, 2006, the internet site shall be operational and, at a minimum, include links to other internet sites that display comparative cost and quality information.

(c) Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost

information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the board shall not publicly release the payment rates of any individual insurer.

(d) The internet site shall be provide updated information on a regular basis, at least annually, and additional comparative cost and quality information shall be posted as determined by the board. To the extent possible, the internet site shall include: (1) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (2) general information related to each service or category of service for which comparative information is provided; and (3) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.

Section 4. The board shall contract with an independent organization to provide the board with technical assistance related to its duties including, but not limited to, development and maintenance of the internet site and the reporting plan required pursuant to section 5. The independent organization shall have a history demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to cost and quality; (ii) identify, through data analysis, quality improvement areas; (iii) work with Medicare, MassHealth, other payers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; (v) establish and maintain security measures necessary to preserve the data; (vi) design and implement health care quality improvement interventions with health care service providers; (vii) identify and, when necessary, develop appropriate measures of cost and quality for inclusion on the website; and (viii) present data on the internet site in a format understandable to consumers. To the extent possible, the organization shall collaborate with other organizations that develop, collect and publicly report cost and quality measures.

Section 5. Any independent organization under contract with the board shall develop and update on an annual basis a reporting plan specifying the cost and quality measures to be included on the internet site.

The reporting plan shall be consistent with the requirements of section 3. The organization shall give consideration to those measures that are already available in the public domain and to whether it is cost effective for the board to license commercially available comparative data and consumer decision support tools. If the organization determines that making available through the internet site only those measures already available in the public domain would not fully comply with section 3 or would not provide consumers with sufficient information to make informed health care choices, the organization shall develop appropriate measures for inclusion on the internet site and shall specify in the reporting plan the sources from which it proposes to obtain the data necessary to construct those measures and any specifications for reporting of that data by insurers and health care providers.

(b) As part of the reporting plan, the organization shall determine for each service that comparative information is to be included on the internet site whether it is more practical and useful to: (1) list that service separately or as part of a group of related services; and (2) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

(c) The independent organization shall submit the reporting plan, and any periodic revisions, to the board. The board shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the board rejects the reporting plan or any revisions, the board shall state its reasons therefor. The reporting plan and any revisions adopted by the board shall be promulgated as a regulation by the commissioner.

Section 6. Insurers and health care providers shall submit data to the board or to the independent organization on behalf of the board, as required by regulations promulgated pursuant to section 5. Any insurer or health care provider failing, without just cause, to submit required data to the board on a timely basis may be required, after notice and hearing, to pay a penalty of $1,000 for each week's delay. The maximum penalty under this section shall be $50,000.

SECTION 5. Chapter 29 of the General Laws is hereby amended by inserting after section 2CCC the following section:—

Section 2DDD. (a) There shall be established and set up on the books of the commonwealth a separate

fund to be known as the Reinsurance Trust Fund. There shall be credited to the fund all amounts received under section 15A of this act. The commissioner of insurance shall authorize expenditures from the fund for the purposes of reimbursing carriers, as defined in section 1 of chapter 176J, for all costs which that the carriers may incur in claims pursuant to section 10 of said chapter 176J and section 7 of chapter 176M. The commissioner of revenue shall collaborate with the commissioner of insurance and the commissioner of health care finance and policy to determine the appropriate methodology and mechanisms by which to the employees, pursuant to said section 15A of this act. 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 necessary to implement this section. The commissioner of insurance shall, not later than October 1 of each year, file a detailed report in writing to 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, pursuant to said section 15A of this act, the methodology used for reimbursing eligible carriers and the disbursements made, by carrier and amount, the fiscal year ending on the preceding June 30. Said commissioner may submit any additional information he considers appropriate and may file recommendations to improve, adjust or modify the mechanism established pursuant to said section 15A of this act.

(b) There shall be a reinsurance trust fund advisory board, consisting of 14 members, who shall be citizens of the commonwealth, to be appointed by the governor, 2 of whom shall be persons representing businesses or employers; 4 of whom shall be persons representing the health care industry, 1 of whom shall be selected from the Massachusetts Association of Health Plans; 1 of whom shall be selected by Blue Cross and Blue Shield of Massachusetts, 1 of whom shall be selected from the Massachusetts Hospitals Association, 1 of whom shall be selected from the Massachusetts Medical Society, 1 of whom shall be selected from the Massachusetts League of Community Health Centers, 1 of whom shall be a representative of a consumer advocacy organization, 1 of whom shall have a background in health policy and economics and 1 of whom shall represent the public. The Advisory board shall designate the chairman of the advisory board by unanimous vote. Members shall serve for a term of 3 years. Vacancies shall be filled by appointment by the governor for the remainder of the unexpired term. All

members shall serve until the qualification of their respective successors. Members shall serve without compensation. The advisory board shall advise the commissioner of insurance and the commissioner of health care finance and policy on the administration, oversight and operation of the fund, including but not limited to, reviewing and making recommendations on assessment methodologies, pursuant to section 18B of chapter 118G of the General Laws, assessment levels, appropriate funding and disbursement levels and other requirements or criteria specific to the fund or its structure. The advisory board shall, from time to time, submit recommendations to the legislature on any legislative changes it deems necessary for the successful operation of the fund or its structure.

SECTION 5½. Chapter 29 of the General Laws is hereby amended by inserting after section 2NNN the following section:—

Section 2OOO. There shall be established and set up on the books of the commonwealth a Health Care Access and Investments Trust Fund which shall be administered by the secretary of health and human services with the counsel, input and recommendations of the MassHealth payment policy advisory board. The purpose of the fund shall be to maintain a world-class health care system by making targeted investments to certain participating Medicaid providers and to accomplish the following:

1) invest in hospitals, community health centers, clinics licensed under section 51 of chapter 111 and physicians who participate in the MassHealth program;

2) encourage MassHealth providers to increase enrollment in the MassHealth program and lower the number of uninsured patients in the commonwealth;

3) provide incentives to MassHealth providers to deliver care and encourage the use of low-cost settings;

4) encourage hospitals to implement safe staffing models, reduce medical errors and invest in technologically-advanced capital equipment; and

5) address the practice of cost-shifting to providers and consumers.

(b) All amounts from the fund shall be subject to appropriation. All interest earned on the amounts in the fund shall be deposited or retained in the fund. The secretary shall seek federal financial participation for any expenditures of these funds. All federal reimbursements received for expenditures from the fund shall be credited to the General Fund."

SECTION 5A. Section 1 of chapter 32 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "Authority", in line 191, the following words:— , Commonwealth Care Health Insurance Exchange Corporation.

SECTION 6. Chapter 32A of the General Laws is hereby amended by inserting after section 10E the following section:—

Section 10F. The commission shall establish a plan of long term care insurance on the terms and conditions it considers to be in the best interest of the commonwealth and its employees. With respect to any long term care insurance which is in effect for an employee there shall be withheld from the salary or wages of the employee the premium for the insurance and the commonwealth shall make no contribution to the premium. The commission shall use its best efforts to ensure that all premium payments by employees are eligible for favorable tax treatment available under federal and state law.

SECTION 6A. Section 2 of chapter 32B of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "commonwealth", in line 65, the following words:— , and any federally recognized Indian Tribe as referenced in 25 U.S. C. section 1771 et seq.

SECTION 7. Section 1 of chapter 62 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out paragraph (c) and inserting in place thereof the following paragraph:—

(c) "Code", the Internal Revenue Code of the United States, as amended on January 1, 1998 and in effect for the taxable year; provided, however, that Code shall mean the Code as amended and in effect for the taxable year for sections 62(a)(1), 72, 223, 274(m), 274(n), 401 to 420, inclusive, 457, 529, 530, 3401 and 3405 but excluding sections 402A and 408(q).

SECTION 7A. Section 1 of chapter 111 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out the definition of "Health care provider" and inserting in place thereof the following definition:—

"Health care provider", any doctor of medicine, osteopathy, or dental science, or a registered nurse, pharmacists, social worker, doctor of chiropractic, or psychologist licensed under the provisions of chapter one hundred and twelve, or an intern, or a resident, fellow, or medical officer licensed under

section 9 of chapter 112, licensed pharmacy, or a hospital, clinic or nursing home licensed under this chapter, and its agents and employees, or a public hospital and its agents and employees.
The definition of "Medical peer review committee" or "committee" of said section 1 of said chapter 111, as so appearing, is hereby amended by adding the following words:— "Medical peer review committee" shall also include a committee of a pharmacy society or association that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care; or a pharmacy peer review committee established by a person or entity that owns a licensed pharmacy or employs pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care.

SECTION 7B. Chapter 73 of the General Laws is hereby amended by inserting after section 2A the following section:—
Section 2B. (a) The general court finds that: (1) in the interest of the commonwealth to promote the prevention of injury and illness of residents; (2) there are individuals and families residing in the commonwealth who lack health insurance coverage for preventative health or primary care services; (e) use of these services has been shown to be effective in reducing the incidence of preventable hospitalization and cost of health care; (4) there are a significant number of students of the medical and health sciences and licensed and certified health professionals located in the commonwealth seeking opportunities to service the public in community settings; (5) there are a number of health programs and facilities in the commonwealth that may benefit from the services of these students and health professionals; (6) students who participate in such programs are likely to seek careers in community settings; and (7) higher education students and retired medical professionals can help address these public health needs through the creation of the Commonwealth Student Health Corps.
(b) The board of higher education shall establish the Commonwealth Student Health Corps to expand opportunities for students of public health and medical professions, practitioners, and active and retired. certified professionals to participate in public service programs that help meet critical community needs. The board shall develop a program to expand and coordinate public and private resources that promote

community service by coordinating supervised students with professionals in public health service programs.

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

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

The purpose and goals of the curriculum-based, community service, learning requirements for students are to: (1) increase opportunities for students throughout Massachusetts to participate in real world, applied learning through curriculum-based, service, learning activities; (2) help improve the state's public health needs; (3) strengthen communities through service; and (4) enhance the ethic of service.

The board, with the alliance, shall:

(1) conduct studies and accredited projects;

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

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

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

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

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

(7) appoint a program director to implement and administer the studies and accredited service projects

initiated under this section.

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

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

(e) A member of the Commonwealth Student Health Corps shall not be considered an employee of the commonwealth entitled to benefits such as worker's compensation or unemployment benefits. A municipality shall not be held liable for any claim arising out of a community service program. Service opportunities shall not replace existing state employees.

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

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

(b) The program shall prepare a comprehensive and aggressive outreach services plan, which shall be updated and filed with the house and senate committees on ways and barriers to and disparities in health care services, including cultural and language differences between health care providers and their patients, limited accessibility of health care facilities and providers, lack of transportation, inadequate understanding of MassHealth and other health care programs by eligible persons and providers who are unfamiliar with the needs of ethnic, racial minority and immigrant persons, families and communities, disparate status, service, care and treatment of minority and immigrant persons and low participation of ethnic and racial minority persons in trials and studies of diseases and ailments, which have a high and negative impact on such persons, families and communities including, but not limited to, asthma, lactose intolerability, diabetes, breast cancer, lupus and sickle cell anemia and any other barriers or disparities, which have a high and negative impact on such persons, families or communities. The plan shall detail a

strategy for providing community-based education and health promotion services to reduce such barriers and disparities and improve public health. The strategy shall include, but not be limited to:

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

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

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

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

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

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

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

Section 24L. (a) There is hereby established the pediatric palliative care program. The program shall be administered by the department, subject to appropriation, pursuant to this section and regulations promulgated hereunder. The program shall assist eligible children with life-limiting illnesses and their families or guardians with services designed to achieve an improved quality of life and to meet the physical, emotional and spiritual needs experienced during the course of illness, death and bereavement. A child under 19 years of age shall be eligible for the program if he meets the requirements established by the department, which shall include: (i) a diagnosis of a life-limiting illness, including but not limited to, cancer, AIDS, congenital anomalies or other advanced illness; provided however, no requirement regarding life expectancy shall be imposed; and (ii) a requirement that an eligible child's family not be covered by a third-party payer for the services provided by the program.

(b) Services provided by the program shall be determined by the department and shall include, but not be limited to, consultations for pain and symptom management, case management and assessment, social services, counseling, bereavement services, volunteer support services and respite services provided by professional or volunteer staff under professional supervision. Services shall be provided by hospice programs licensed under section 57D that meet such other criteria as the department may establish by regulation, including demonstrated expertise in pediatric palliative care. The department may, by regulation, establish limits on services provided by the program. The program shall not give rise to enforceable legal rights in any party or an enforceable entitlement to the services described in this section and nothing shall be construed as giving rise to any such enforceable legal rights or enforceable entitlement."

SECTION 9. Section 52 of chapter 111 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "institution", in lines 35 and 36, the following words:— but, any Medicare-certified entity or provider that operates exclusively for the purpose of providing ambulatory surgery services, as defined by section 25B, shall be defined a clinic for purposes of licensure under section 51.

SECTION 10. Section 25C of said chapter 111, as so appearing, is hereby amended by adding the following paragraph:—

Notwithstanding the any general or special law or rule or regulation to the contrary, an acute-care hospital may acquire new technology or major movable equipment, cyberknifes, positron emission tomography machines or other diagnostic equipment used to provide innovative service, without obtaining a determination of need from the department of public health, and that all the uses associated with those technologies shall not be a substantial change in services.

SECTION 10A. Section 203 of said chapter 111, as so appearing, is hereby amended by adding the following subsection:—
(g) A licensed pharmacy may establish a pharmacy peer review committee to evaluate the quality of pharmacy services or the competence of pharmacists and suggest improvements in pharmacy systems to enhance patient care. The committee may review documentation of quality-related activities in a pharmacy, assess system failures and personnel deficiencies, determine facts, and make recommendations or issue decisions in a written report that can be used for contiguous quality improvements purposes. A pharmacy peer review committee includes the members, employees, and agents of the committee, including assistants, investigators, attorneys, and any other agents that serve the committee in any capacity.

SECTION 10B. Said section 204 of said chapter 111, as so appearing, is hereby further amended by inserting after the word "medicine," in lines 7 and 12, each time it appears, the following word, in each instance:— pharmacy,.

SECTION 10C. Said section 204, of said chapter 111, as so appearing, is hereby further amended by inserting after the word "medicine,", in line 28, the following word:— pharmacy,."

SECTION 10D. Section 2 of chapter 112 of the General Laws, as so appearing, is hereby amended by adding the following paragraph:—
The scope of practice of physicians whose certificates of registration are granted or renewed pursuant to this paragraph may be restricted as the board may provide by regulation. Notwithstanding any law or regulation to the contrary, physicians licensed to provide voluntary care shall not be required to carry medical malpractice insurance coverage for the care, but shall be subject to all other requirements the

board has established or established for physicians concerning quality of care, continuing education requirements and competence to practice medicine. The board shall promulgate the regulations no later than 3 months after the effective date of this act.

SECTION 11. Chapter 112 of the General Laws is hereby amended by inserting after section 12B the following section:—

Section 12B½. A physician duly registered under section 2, 2A, 9, 9A or 9B, a physician assistant duly registered under section 9I or his employing or supervising physician, and a nurse duly registered or licensed under section 74, 74A or 76, or resident in another state, in the District of Columbia or in a province of Canada, and duly registered therein, who, in good faith, as a volunteer and without fee, renders uncompensated care or treatment, other than in the ordinary course of his practice, shall not be liable in a suit for damages as a result of his acts or omissions, nor shall he be liable to a hospital for its expenses if, under such uncompensated care conditions, he orders a person hospitalized or causes his admission.

SECTION 11A. Said chapter 112 is hereby further amended by inserting after section 12CC the following section:—

Section 12DD. (a) For the purposes of any civil action against a person licensed by the board of registration in medicine, any expression of regret or apology made by or on behalf of the person, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability for any purpose and shall not be admissible in any civil action against such person.

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

SECTION 11B. Section 9 of chapter 118E, as appearing in the 2004 Official Edition, is hereby amended

by striking out, in lines 14 to 18, inclusive, the words "provided, further, that said benefits shall be available to otherwise eligible persons seeking admission to and residents of long-term care facilities whose income and resources are insufficient to meet the cost of their medical care as determined by the financial eligibility requirements of said program." and inserting in place thereof the following words:— provided, further, that the benefits shall be available to otherwise eligible persons seeking long term care whose income and resources are insufficient to meet the cost of their medical care as determined by the financial eligibility requirements of the program For the purposes of this chapter, the division shall establish clinical eligibility for a long term care benefit, so-called. Any person determined by the division as clinically eligible for the long term care benefit shall be given the choice of care setting that is the least restrictive and most appropriate to meet his needs. The dollars that are provided for the long term care benefit shall follow the individual as his setting of care changes.

The division shall promulgate regulations to implement this section and shall submit a Section 1115(a) research and demonstration waiver no later than July 1, 2006 to implement this section. The waiver shall establish an income eligibility up to 300 percent of the federal benefit rate under the supplemental security income program, and an asset test of not less than $10,000. The waiver shall requirements established for such waivers.

A person seeking admission to a long term care facility paid for by MassHealth shall receive pre-admission counseling for long term care services, which shall include an assessment of community-based service options. A person seeking care in a long term care facility on a private pay basis shall be offered the pre-admission counseling on a voluntary basis. For the purpose of this section, all pre-admission counseling shall be conducted by the executive office of elder affairs, or its subcontractors. The division shall report to the general court on an annual basis the number of individuals who received pre-admission counseling under this section, and the number of diversions to the community generated by this pre-admission counseling program, so-called."

SECTION 11C. Said chapter 112 is hereby amended by inserting after section 45A the following section:—

Section 45B. (a) The scope of practice of a dentist whose certificate of registration is granted or renewed

under this section may be restricted as the board may provide by regulation.

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

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

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

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

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

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

(e) The board of registration in dentistry shall adopt regulations to carry out this section not later than 3 months following the effective date of this act.

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

(c) children and adolescents, from birth to 18 years, inclusive, whose financial eligibility as determined

by the division exceeds 133 per cent but is not more than 300 per cent of the federal poverty level, including such children and adolescents made eligible for medical benefits under this chapter by Title XXI of the Social Security Act.

SECTION 12A. Subsection (2) of section 9A of chapter 118E of the General Laws, as so appearing, is further amended in line 115 by striking out the figure "133" and inserting in place thereof the following figure:— "200".

SECTION 12B. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 80, the figure "133" and inserting in place thereof the following figure:— 200.

SECTION 13. Chapter 118E of the General Laws is hereby amended by striking out section 9C, as appearing in the 2004 Official Edition, and inserting in place thereof the following section:—

Section 9C. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Eligible employee", (i) an employee of an eligible or qualified employer; (ii) who resides in the commonwealth; (iii) who has not attained age 65; and (iv) who meets the financial and other eligibility standards set forth in regulations promulgated by the division; provided, however, that the gross family income standard shall not exceed 300 per cent of the federal poverty level.

"Eligible employer", (i) an individual or an unincorporated business that employs at least 1 resident of the commonwealth; (ii) a corporation, including a foreign corporation, other than a governmental entity, that employs at least 1 resident of the commonwealth; or (iii) a corporation or an unincorporated entity that is exempt from taxation under the provisions of section 501(c) of the Internal Revenue Code of the United States, as amended and in effect for the taxable year; provided however, that to be eligible, the employer shall employ not more than 75 employees and shall meet the eligibility requirements set forth in this section and in regulations promulgated by the division; and provided, further, that the method of determining the number of employees an employer has and the amount and types subsidies available to an eligible employer based upon employee family status shall be determined by the division.

"Eligible self-employed husband and wife", a married couple with or without dependents: (i) where

either spouse receives gross income from self employment; (ii) where both spouses reside in the commonwealth; (iii) where neither spouse has attained age 65; and (iv) who meets the financial and other eligibility standards set forth in regulations promulgated by the division; provided, however, that the gross family income standard shall not exceed 300 per cent of the federal poverty level.

"Eligible self-employed single individual", a person with or without dependents: (i) who receives gross income from self-employment; (ii) who resides in the commonwealth; (iii) who has not attained age 65; and (iv) who meets the financial and other eligibility standards set forth in regulations promulgated by the division; provided, however, that the gross family income standard shall not exceed 300 per cent of the federal poverty level.

"Qualified medical insurance", "qualified medical insurance", "qualified individual medical insurance" "qualified two-person family medical insurance" and "qualified family medical insurance" as defined in regulations promulgated by the commissioner of insurance pursuant to section 3C of chapter 175.

(b) The division shall assist the director of labor and workforce development, subject to this section, to establish Health Care Plus, an insurance reimbursement program for certain employees or employers for the purpose of reducing or eliminating the amount of contributions or payments made by such employees or employers toward the cost of qualified medical insurance and which shall consist of the following 3 programs:

(1) an employee subsidy program to assist eligible employees with reducing or eliminating their contribution to premiums or other employment-based costs of qualified medical insurance provided by an eligible employer for which the employer pays not less than 50 per cent of the premium or cost; provided, however, that the amount of the subsidies may vary with the contribution of the employees to the cost of their qualified medical insurance, and with the income of the employees and their families, in accordance with a sliding fee schedule set forth in regulations promulgated by the division, and may be paid directly to or on behalf of eligible employees.

(2) a subsidy program to assist the self-employed single individual and the self-employed husband and wife with reducing or eliminating the cost of premiums or other costs of purchasing qualified medical insurance; provided, however, that the amount of subsidies may vary with the income or insurance costs of the persons and their families, in accordance with a sliding fee schedule set forth in regulations

promulgated by the division, and may be paid directly to or on behalf of those persons; and provided further, that the division may choose various options in establishing the program, including but not limited to, establishing: (i) subsidies for the self-employed which may be for an amount which incorporates payments otherwise available to such self-employed individual or spouse under subsection (e); (ii) sliding fee schedules that may incorporate such payments; or (iii) sliding fee schedules which may be otherwise adjusted so that such persons receive overall assistance comparable, but not necessarily identical, in its effect to that received by similarly situated eligible employees under the program established under clause (3).

(3) an employer health care incentive program for the purpose of reducing the cost to employers of providing or maintaining qualified medical insurance for their eligible low-income employees; provided, however, that the eligible employer shall pay at least 50 per cent of the premium cost of such qualified medical insurance; and provided further, that the division may limit payments under this program, using a reasonable methodology, in relation to the participation of said employer's employees in the subsidy program provided for in clause (1).

(c) The subsidy programs shall constitute additional medical benefits to expansion beneficiaries in accordance with the terms and conditions of a demonstration project as defined in subsection (1) of section 9A. The division may, subject to the terms and conditions of the demonstration project, include in the demonstration project the program described in paragraph (c) of subsection (2) of section 9A; provided, however, that the division may implement the program if it is not included within the demonstration project.

(d) The amount of payments for each employer under clause (3) of subsection (b) shall be as follows: (i) $600 for each eligible employee for whom the eligible employer pays at least 50 per cent of the cost of qualified individual medical insurance; (ii) $1,200 for each eligible employee for whom the eligible employer pays at least 50 per cent of the cost of qualified two-person family medical insurance, and (iii) $1,500 for each eligible employee for whom the eligible employer pays at least 50 per cent of the cost of qualified family medical insurance; provided, however, that the division may use any reasonable data sources in determining the number of eligible employees of an eligible employer qualifying for such payments under this subsection. The director of labor and workforce development, in collaboration with

the division, may implement annual inflation increases to said payments, based on certain criteria as determined by the director and the division and subject to the requirements of the budget neutrality plan established by section 9B.

(e) The amount of payments for each self-employed single individual or each self-employed husband and wife under clause 2 of subsection (b) may include the following amounts: (i) $600 for an eligible self-employed single individual if the individual purchases qualified individual medical insurance; (ii) $1,200 for an eligible self-employed single individual with a dependent child or for an eligible self-employed husband and wife filing a joint return and who have no dependent children, if the individual or husband and wife purchase qualified two-person family medical insurance; or (iii) $1,500 for an eligible self-employed single individual with two or more dependent children, or for an eligible self-employed husband and wife filing a joint return and who have dependent children, if the individual or the husband and wife purchase qualified family medical insurance; provided, however, that the payment shall not exceed the amount of the net premium cost to the self-employed persons of the insurance, and shall be in conformity with the regulations of the division. The director of labor and workforce development, in collaboration with the division, may implement annual inflation increases to the payments, based on certain criteria as determined by the director and the division and subject to the requirements of the budget neutrality plan established by section 9B.

(f) The director of labor and workforce development, in collaboration with the division, may require, as a condition for receiving benefits under this section and solely for the purposes of determining the eligibility of any employee. self-employed single individual, or self-employed husband and wife, the consent of any applicant to the disclosure to the division and to the United States Department of Health and Human Services pursuant to subsection (10) of prior year's tax information and any other information demonstrating the income level of such persons. The director in collaboration with the division, may employ additional eligibility criteria to ensure, where appropriate, that no person or employer receives payments or assistance under more than 1 category of persons or employers eligible for payment or assistance.

(g) The income and other eligibility requirements for the programs provided under subsection (a) may be modified from time to time to ensure that projected expenditures for such benefits are within the

amounts available and within the amounts projected to be available. The director of labor and workforce development, in collaboration with the division, shall set forth in enrollment of qualified individuals regulations changes in eligibility requirements, including changes necessary to ensure compliance with the budget neutrality requirements of section 9B.

(h) The director of labor and workforce development, in collaboration with the division, may, in lieu of cash payments or otherwise, issue to individuals vouchers or other documents certifying that the division will pay a specified amount for medical insurance under specified circumstances.

(i) If, during the term of the demonstration project as it pertains to programs authorized under this section, the director of labor and workforce development, in collaboration with the division, proposes modifications to the demonstration project which require approval by the director, the division may implement said modifications upon the director's approval, subject to the terms of that approval, and, if required, the enactment of authorizing legislation.

(j) Data and information obtained by the division pursuant to subsection (f) to determine eligibility under this chapter shall be available for inspection by the director or his designee for the specific purpose of substantiating expenditures made under this section.

(k) The division shall establish an intragovernmental service agreement or collaboration with the director of labor and workforce development for the purposes of implementing the provisions of this chapter and may arrange with other agencies of the commonwealth, including the department of revenue, as provided in subsection (11) of section 9A, to administer said programs (1) This section shall not give rise to, nor be construed as giving rise to, enforceable legal rights for any party or an enforceable entitlement to benefits other than to the extent that such rights or entitlements exist pursuant to the regulations of the commissioner of insurance and the regulations of the commissioner of revenue subsection (a), the regulations of the division, or the terms and conditions of the demonstration project.

(m) Expenditures under this section shall, subject to appropriation, be funded by the MassHealth insurance reimbursement program account established by subsection (c) of section 18 of chapter 118G. Aggregate expenditures made by the director of labor and workforce development, in collaboration with the division, for the insurance reimbursement program shall not exceed $120,000,000 in any fiscal year, and shall be subject to the requirements of the budget neutrality plan established by section 9B.

(n) The director of labor and workforce development, in collaboration with the division, shall provide quarterly reports to the committee on health care financing and to the house and senate committee on ways and means on the implementation status and budget impact of the programs established under this section. The programs may be offered separately and may be implemented at different times, and a plan relative to each program may be submitted separately.

SECTION 13A. The fourth paragraph of section 12 of said chapter 118E, as so appearing, is hereby amended by adding the following sentence:— The executive office of health and human services shall adopt regulations which restrict eligibility or covered services only after public notice and hearing.

SECTION 13A½. Chapter 118E of the General Laws is hereby amended by inserting after section 12 the following sections:—

Section 12A.

(a) Any prior authorization process required by the division to obtain coverage for a prescription drug shall comply with this section and with 42 U.S.C. section 1396r-8(d).

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

(i) the drug is medically necessary; and

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

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

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

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

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

(2) The prior authorization process shall ensure real-time receipt of requests by telephone, voice mail,

facsimile, electronic transmission or mail on a 24-hour, 7 days per week basis.

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

(4) Any request for authorization or approval of a drug that the prescriber: indicates is for an emergency or urgent condition; and includes the clinical reasons for the request shall be responded to within 4 hours of the time the program or participating health benefit plan receives the request.

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

(6) The division shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least 1 form capable of being copied shall contain known patient information.

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

(f) A denial of authorization for coverage shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A.

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

Section 12B.

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

(b) The commissioner shall provide quarterly reports on the progress of negotiating supplemental rebates pursuant to this section to the joint committee on health care and the house and senate committees on ways and means. By September 1, 2006, the commissioner shall include with the next-occurring quarterly report a cost-benefit analysis of alternative negotiation strategies, including strategies used by the state Medicaid agencies in the states of Florida and Michigan to secure supplemental rebates, and any other alternative negotiation strategy that might secure lower net prescription drug costs.

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

Section 12C.

(a) The division shall seek a prescription drug discount program waiver from the Centers for Medicare

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

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

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

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

SECTION 13B. Section 16C of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 4 and 20, the figure "200", each time it appears, and inserting in place thereof, in each instance, the following figure:— 300.

SECTION 13B1/5. Chapter 118E of the General Laws, is hereby amended by inserting after section 16D the following section:—

Section 16E. Notwithstanding a member's coverage type or enrollment in a managed care organization, the division shall provide reimbursement to providers for all medically necessary non-emergency ambulance and wheelchair van trips provided to enrollees in the MassHealth Basic and MassHealth Essential plans. Reimbursement to these providers shall not exceed an aggregate of $300,000 in each fiscal year.

Medical necessity for non-emergency ambulance service shall be established by the completion of a medical necessity form signed by a physician, physician's designee, physician assistant, nurse midwife, dentist, nurse practitioner, managed care representative, or registered nurse. The member's record must support the information given on the medical necessity form. The transportation provider is responsible for the completeness of the medical necessity forms. The completed medical necessity form must be kept by the transportation provider as a record for 4 years from the date of service.

SECTION 13B2/5. Said chapter 118E is hereby amended by striking out section 33 and inserting in place thereof the following new section:—

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

SECTION 13B3/5. Section 16D of said chapter 118E, as so appearing, is hereby amended by striking out subsections (3), (4) and (6).

SECTION 13B4/5. Said chapter 118E is hereby further amended by adding the following section:—

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

SECTION 13C. Section 1 of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Non-acute hospital" the following definition:

"Non-providing employer", an employer of a person receiving free care or Medicaid, so-called, pursuant to chapter 118E; provided, however, that the term "non-providing employer" shall not include:

(i) an employer that, for such person receiving free care or Medicaid, offers to pay for or arrange for the purchase of health insurance coverage; (ii) an employer that is signatory to or obligated under a negotiated, bonafide collective bargaining agreement between such employer and bonafide employee representative which agreement governs the employment conditions of such person receiving free care:

or (iii) an employer that employs not more than 50. For the purposes of this definition, an employer shall not be considered to pay for or arrange for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers by making or arranging for any payments to the uncompensated care pool.

SECTION 13D. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Pool", as so appearing, the following definition:
"Payments from Non-providing Employers", all amounts paid to the Uncompensated Care Trust Fund by non-providing employers.

SECTION 13E. Clause (h) of subsection (2) of section 9A of chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after the words "eligibility", in line 112, the following words:— "provided that the division shall not establish disability criteria for applicants or recipients which are more restrictive than those criteria authorized by Title XVI of the Social Security Act, 42 USC Section 1381 et seq.

SECTION 14. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Uninsured patient", as so appearing, the following definition:—
"Voluntarily uninsured employee", an uninsured patient: (i) whose gross family income exceeds 300 per cent of the federal poverty level; (ii) whose employer has offered to pay for or arrange for the purchase of health insurance; and (iii) who has declined to obtain such health insurance.

SECTION 15. Section 6 of said chapter 118G, as so appearing, is hereby amended by inserting after the first paragraph, the following paragraph:—
In addition, such uniform reporting shall provide the name and address and such other identifying information as may be needed relative to the employer of any patient for whom health care services were rendered pursuant to this chapter and for whom reimbursement from the uncompensated care pool has been requested.

SECTION 16. Said chapter 118G of the General Laws is hereby amended by inserting after section 6A,

as so appearing, the following 2 sections:—

Section 6B. Notwithstanding any general or special law to the contrary, an applicant for uncompensated care pool assistance shall, if eligible, be enrolled in MassHealth pursuant to section 9A, chapter 118E or in Health Care Plus, formerly the Insurance Partnership, as provided in section 9C of said chapter 118E. An applicant deemed ineligible for either program, or who is self-employed and who is unable to make all or part of the payment for health services, shall provide the name and address of his employer or, if self-employed, his name, address, social security number and date of birth. The director of labor and workforce development, in collaboration with the division, shall collaborate with the division of insurance and the department of revenue to implement this section and sections 6C and 18 and section 41 of chapter 268. Section 6C. The division shall promulgate a form labeled "Health Insurance Responsibility Disclosure" to be completed and signed, under oath, by every employer and employee doing business in the commonwealth. The form shall indicate whether the employer has offered to pay for or arrange for the purchase of health care insurance, whether the employee has accepted or declined such coverage and whether the employee has an alternative source of health insurance coverage. The form shall contain a statement that an employee who chooses to decline health insurance coverage offered by an employer shall be legally responsible for that employee's health care costs, if any, and shall be charged for the use of any uncompensated care pool services. The division may make arrangements with other agencies of the commonwealth, including the department of revenue, to distribute and collect forms to all employers and employees in the commonwealth.

SECTION 17. Said chapter 118G is hereby further amended by inserting after section 11, as so appearing, the following section:—

Section 11A. (a) The division shall monitor and review payments to MassHealth providers as specified in section 13 of chapter 118E. The division, in consultation with the state auditor, shall annually prepare analyses for the advisory board established pursuant to said section on the following:

(i) a comparison of Title XIX and Title XVIII provider rates for comparable services;

(ii) an historical analysis comparing Medicare and Medicaid annual inflation updates;

(iii) adequacy of medicaid payments to providers with particular attention to community hospitals,

physicians and other providers located in rural and isolated areas;

(iv) adequacy of Medicaid payment for emergency care rendered as required by 42 USC 1395(dd), women's health care provided by clinics licensed under section 51 of chapter 111 and competent interpreter services provided pursuant to section 25J of chapter 111; and

(v) Adequacy of Medicaid payments to allow providers to cover at least half the cost of employee health care insurance.

(b) The division shall annually transmit to the governor, the speaker of the house and president of the senate, a MassHealth cost-shifting report. The MassHealth cost-shifting report shall determine the extent to which rates charged by providers to health insurance plans are increased due to inadequate payments by commonwealth governmental units under Title XIX. The report shall further estimate the increased costs of health insurance plan premiums due to inadequate payments by commonwealth governmental units under Title XIX. In preparing the report, the state auditor shall consult with representatives of providers and shall have access to all information of the division.

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

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

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

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

proportion of employees for whom the non-providing employer provides health insurance.

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

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

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

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

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

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

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

(k) All surcharge payments up to $50,000,000 made under this section shall be deposited into the Reinsurance Trust Fund, established in section 2DDD of chapter 29. All subsequent surcharge payments shall be deposited into the General Fund.

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

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

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

(o)No employer shall discriminate against any employee on the basis of the employee's or the employee's dependent's receipt of uncompensated care pool services, the employee's reporting or disclosure of his employer's identity and other information about the employer, the employee's completion of a health insurance responsibility disclosure form, or any facts or circumstances relating to "free rider" surcharges assess against the employer in relation to the employee. Violation of this sub-section shall constitute a per se violation of chapter 93A.

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

SECTION 18A. The General Laws are hereby amended by inserting the following chapter:

Chapter 118H. The Massachusetts Prescription Drug Fair Pricing Program.

Section 1.

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

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

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

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

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

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

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

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

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

(1) the division of medical assistance;

(2) the executive office of elder affairs;

(3) the group insurance commission;

(4) the department of public health;

(5) the department of mental health;

(6) the department of mental retardation;

(7) the department of corrections; and

(8) the division of employment and training.

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

Section 2.

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

(b) The prescription drug procurement unit, created by section 62 of chapter 177 of the acts of 2001, shall implement all or part of the program to the extent permitted by federal law. The secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of the departments of public health, mental health and mental retardation may renegotiate or amend existing contracts for the purchase of prescription drugs, including a contract made in conformance with said section 62, if such renegotiation or amendment is necessary to implement all or part of the program and will be of economic benefit to the health benefit plans subject to such contracts and to the beneficiaries of such plans. A renegotiated or substituted contract shall be designed to improve the overall quality of integrated health care services provided to the beneficiaries of these plans. Section 3.

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

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

(1) operating statements of the pharmacy benefit manager;

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

(3) sources of rebate revenue and non-rebate revenue and the amounts of revenue from these sources;

(4) rebate management fees collected;

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

(6) the terms and conditions of sales or exchanges of prescription drug data concerning beneficiaries or the prescribing practices of the providers.

(c) No contract shall be signed with a pharmacy benefit manager that has entered into an agreement or engaged in 1 or more of the following practices, unless a majority of state agency participants in the program determines, after consideration of all relevant circumstances, that such agreement or practice furthers the financial interests of the commonwealth and does not adversely affect the financial or medical interests of beneficiaries:

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

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

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

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

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

Section 4.

(a) The program shall include the following components:

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

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

encouraged to participate in the program.

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

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

(B) meet at least quarterly;

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

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

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

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

drugs; 1 representative of a senior citizens advocacy group; 1 representative of a disability advocacy group; and 1 representative of a statewide advocacy group representing the interests of MassHealth members.

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

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

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

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

Section 5.

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

(i) the drug is medically necessary; and

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

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

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

(b) The prescriber's certification concerning whether a particular drug has been, or is expected to be,

ineffective in treating the patient or is expected to cause an adverse or harmful reaction shall be final.

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

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

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

(2) The prior authorization process shall ensure real-time receipt of requests by telephone, voice mail, facsimile, electronic transmission or mail on a 24-hour, 7 days per week basis.

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

(4) Any request for authorization or approval of a drug that the prescriber: indicates is for an emergency or urgent condition; and includes the clinical reasons for the request shall be responded to within 4 hours of the time the program or participating health benefit plan receives the request.

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

(6) The program or participating plan shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription and designed to be completed without unnecessary delay. The form shall be

capable of being stamped with information relating to the participating provider and, if feasible, at least 1 form capable of being copied shall contain known patient information.

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

(g) A denial of authorization for coverage shall be subject to an administrative fair hearing and to all rights under section 14 of chapter 30A.

Section 6.

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

Section 7.

(a) The commissioner of health and human services or another commissioner of a participating state

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 19. Chapter 149 of the General Laws is hereby amended by inserting after section 6D, as so appearing, the following new section:

Section 6D½. No employee shall be penalized by an employer as a result of such employee's filing of an application to the uncompensated care pool or otherwise providing notice to the division of health care finance and policy or to a health care provider in regard to the need for health care services for that employee that results in the employer being required to reimburse the pool in whole or in part.

SECTION 20. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby amended by striking out subsection (3) and inserting in place thereof the following subsection:—

(3) It purports to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 25 years and any other person dependent upon the policyholder; provided, however, that where a policy provides for termination of a dependent child's coverage at a specified age and where such a child is mentally or physically incapable of earning his own living on the termination date, the policy shall continue to insure such child while the policy is in force and so long as such incapacity continues, if due proof of such incapacity is received by the insurer within 31 days of such termination date. The term "dependent children" as used in this subsection shall include children of adopting parents during the pendency of adoption proceedings under chapter 210; and.

SECTION 21. Chapter 175 of the General Laws is hereby amended by inserting after section 110K the following section:

Section 110L. Every policy of insurance issued or subsequently renewed shall provide coverage to persons who are college age, non-student dependents, up to age 25, who are unemployed and have no other form or type of health insurance. This paragraph shall apply to any policy issued or renewed within or without the commonwealth and which covers residents of the commonwealth.

SECTION 22. Said chapter 175 is hereby amended by inserting after section 111H, the following

section:—

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit. (b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

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

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least 1 mandated benefit unless the carrier continues to offer at least 1 policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION 23. Chapter 176A of the General Laws is hereby amended by inserting after section 1D the

following section:—

Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 8B;

(2) prenatal care, childbirth and postpartum care as set forth in section 8H;

(3) cytologic screening and mammographic examination as set forth in section 8J;

(3A) diabetes-related services, medications, and supplies as defined in section 8P;

(4) early intervention services as set forth in said section 8B; and

(5) mental health services as set forth in section 8A; provided however, that if the contract limits coverage for outpatient physician office visits, the commissioner shall not disapprove the contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 8A, as long as such coverage is at least as extensive as coverage under the contract for outpatient physician services.

(c) The commissioner shall not approve a contract that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least 1 contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.

SECTION 24. Chapter 176A of the General Laws is hereby amended by inserting after section 8Y the following section:—

Section 8Z. Any subscription certificate under a group nonprofit hospital service agreement, except

certificates which provide supplemental coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a principal place of employment within the commonwealth, coverage to persons who are college age, non-student dependents, up to age 25, who are unemployed and have no other form or type of health insurance.

SECTION 25. Chapter 176B of the General Laws is hereby amended by inserting after section 4Y the following section:—

Section 4Z. Any subscription certificate under an individual or group medical service agreement which shall be delivered or issued or renewed in this commonwealth shall provide as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage to persons who are college age, non-student dependents, up to age 25, who are unemployed and have no other form or type of health insurance.

SECTION 26. Said chapter 176B is hereby further amended by inserting after section 6B, the following section:—

Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 4C;

(2) prenatal care, childbirth and postpartum care as set forth in section 4H;

(3) cytologic screening and mammographic examination;

(3A) diabetes-related services, medications and supplies as defined in section 4S;

(4) early intervention services as set forth in said section 4C; and

(5) mental health services as set forth in section 4A; provided however, that if the subscription certificate limits coverage for outpatient physician office visits, the commissioner shall not disapprove the subscription certificate on the basis that coverage for outpatient mental health services is not as

extensive as required by said section 4A, as long as such coverage is at least as extensive as coverage under the subscription certificate for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least 1 subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION 27. Chapter 176G of the General Laws is hereby amended by inserting after section 4Q the following section:—

Section 4R. A health maintenance contract shall provide coverage to persons who are college age, non-student dependents, up to age 25, who are unemployed and have no other form or type of health insurance, as required by section 110L of chapter 175.

SECTION 28. Said chapter 176G of the General Laws is hereby amended by inserting after section 16 the following 2 sections:

Section 16A. (a) The commissioner shall not disapprove or reject a health maintenance contract solely on the basis that it includes any of the following provisions:

(1) a deductible that is consistent with the requirements set forth in section 223 of the Internal Revenue Code. or any successor statute;

(2) reasonable and actuarially sound co-insurance for covered services; or

(3) reasonable annual limits on coverage for physician office visits, outpatient laboratory and diagnostic services and other outpatient services; provided, however, that an annual unit of service limit on coverage for a particular category of services shall be deemed to be reasonable if the health maintenance organization submits an actuarial memorandum demonstrating that the unit of service limit is not less

than 2 times the average expected utilization for that category of services, and that an annual dollar limit on coverage for a particular category of services shall be deemed to be reasonable if the carrier submits an actuarial memorandum demonstrating that the dollar limit is not less than 4 times the average expected level of incurred claims for that category of services.

(b) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

Section 16B. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 4;

(2) prenatal care, childbirth and postpartum care as set forth in said section 4 and section 4I;

(3) cytologic screening and mammographic examination as set forth in said section 4;

(3A) diabetes-related services, medications and supplies as defined in section 4H;

(4) early intervention services as set forth in said section 4; and

(5) mental health services as set forth in section 4M; provided however, that if the health maintenance contract limits coverage for outpatient physician office visits pursuant to section 16, the commissioner shall not disapprove the health maintenance contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4M as long as such coverage is at least as extensive as coverage under the health maintenance contract for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least 1 mandated benefit unless the health maintenance organization continues to offer at least 1 health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to

any employee within 12 months.

SECTION 29. Chapter 176J of the General Law is hereby amended by adding the following section:— Section 10. (a) The commissioner shall reimburse a carrier an amount equal to 90 per cent of claims costs in any calendar year between the reinsurance threshold and the reinsurance limit attributable to any eligible employee or dependent of an eligible small business with not more than 5 eligible employees. The initial reinsurance threshold shall be $100,000. The initial reinsurance limit shall be $500,000. The commissioner shall increase the reinsurance threshold and limit on an annual basis by an amount consistent with medical costs trends in the small group market.

(b) A carrier's cost and utilization trends applicable to premiums charged to eligible small businesses shall reflect anticipated reimbursements pursuant to this section.

(c) Reimbursements to carriers pursuant to this section shall be made from the Individual Group Reinsurance Fund established in section 2DDD of chapter 29.

(d) The commissioner shall promulgate regulations necessary to implement this section. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund.

SECTION 30. Section 2 of chapter 176M of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:—

(d) A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed issue health plan established pursuant to subsection (c) and may make available to eligible individuals up to 6 alternative guaranteed issue health plans with benefits and cost-sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan. A carrier may offer 1 alternative plan that is the alternative plan that was offered by the a carrier as of January 1, 2006, as modified from time to time in the ordinary course of business. A carrier may offer not more than 3 alternative benefit plans that satisfy the requirements set forth in section 223 of the Internal Revenue Code, or any successor statute. A carrier may offer not more than 2 alternative benefit plans that include reasonable and medically appropriate annual limits on coverage for physician office

visits and outpatient services. A carrier shall not make available an alternative plan unless the plan has been filed with and approved by the commissioner of insurance. The commissioner shall approve an alternative plan if it: (1) is consistent with the requirements of the carrier's licensing statute; (2) contains a disclosure form, which shall be provided to a potential insured, that clearly and concisely states the limitations on the scope of health services and any other benefits to be provided, including an explanation of any deductible, co-insurance or co-payment feature; and (3) offers a 10-day free look period in compliance with chapter 176D and any regulations promulgated thereunder. A carrier shall adhere to all other provisions of this chapter when offering any guaranteed issue health plan. The commissioner shall promulgate regulations relative to the alternative plans permissible pursuant to this section. The regulations shall establish parameters for cost-sharing and benefit limits applicable to alternative plans so as to reduce the potential for adverse selection between carriers offering the same type of alternative plan. The regulations shall permit a health maintenance organization to offer alternative guaranteed-issue health plans that are consistent with sections 16A and 16B of chapter 176G.

SECTION 31. Said chapter 176M is hereby further amended by striking out section 7, as so appearing, and inserting in place thereof the following section:—

Section 7. (a) The commissioner shall reimburse a carrier an amount equal to 90 per cent of claims costs in any calendar year between the reinsurance threshold and the reinsurance limit attributable to an eligible individual or dependent. The initial reinsurance threshold shall be $100,000. The initial reinsurance limit shall be $500,000. The commissioner shall increase the reinsurance threshold and limit on an annual basis by an amount consistent with medical cost trends in the nongroup market.

(b) A carrier's cost and utilization trends applicable to premiums charged for guaranteed-issue health plan shall reflect anticipated reimbursements pursuant to this section.

(c) Reimbursements to carriers pursuant to this section shall be made from the Individual Group Reinsurance Fund established in section 2DDD of chapter 29.

(d) The commissioner shall promulgate regulations necessary to implement this section. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund.

SECTION 32. Section 1 of chapter 176O of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the definition of "Health care services" the following definition:—

"Hospital-based physician", a pathologist, anesthesiologist, radiologist or emergency room physician who practices exclusively within the inpatient or outpatient hospital setting and who provides health care services to a carrier's insureds only as a result of insureds being directed to the hospital inpatient or outpatient setting. This definition may be expanded, upon consultation with the Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Association of Health Plans and Blue Cross and Blue Shield of Massachusetts, by regulation to include additional categories of physicians who practice exclusively within the inpatient or outpatient hospital setting and who provide health care services to a carrier's insureds only as a result of insureds being directed to the hospital inpatient or outpatient setting.

SECTION 33. Said chapter 176O is hereby amended by inserting after section 2 the following 2 sections:—

Section 2A. (a) The bureau shall adopt the "Integrated Massachusetts Application for Initial Credentialing/Appointment" and the "Integrated Massachusetts Application for Recredentialing/Re-Appointment" and any revisions thereto, as developed and updated from time to time by the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts Association of Health Plans and Blue Cross Blue Shield of Massachusetts as the statewide uniform physician credentialing application forms. Such forms shall not be applicable in those instances where the carrier has both delegated credentialing to a provider organization and does not require submission of a credentialing application.

(b) A carrier shall not use any initial physician credentialing application form other than the uniform initial physician application form or a uniform electronic version of the form. A carrier shall not use any physician recredentialing application form other than the uniform physician recredentialing application form or a uniform electronic version of the form.

(c) A carrier shall act upon and complete the credentialing process for 95 per cent of complete initial physician credentialing applications submitted by or on behalf of a physician applicant within 30

calendar days of receipt of a completed application or within 45 calendar days if the carrier provides its services on a national basis. An application shall be considered complete if it contains all of the following elements.

(i) the application form is signed and appropriately dated by the physician applicant;

(ii) all information on the application is submitted in a legible and complete manner and any affirmative answers are accompanied by explanations satisfactory to the carrier;

(iii) a current curriculum vitae with appropriate required dates;

(iv) a signed, currently dated applicant's Authorization to Release Information form:

(v) copies of the applicant's current licenses in all states in which the physician practices;

(vi) a copy of the applicant's current Massachusetts controlled substances registration and a copy of the applicant's current federal Drug Enforcement Administration controlled substance certificate or, if not available, a letter describing prescribing arrangements;

(vii) a copy of the applicant's current malpractice face sheet coverage statement including amounts and dates of coverage;

(viii) a hospital letter or verification of hospital privileges or alternate pathways;

(ix) documentation of board certification or alternate pathways;

(x) documentation of training, if not board certified;

(xi) documentation that there are no affirmative responses on questions related to quality or clinical competence;

(xii) there are no modifications to the applicant's Authorization to Release Information Form;

(xiii) there are no discrepancies between the information submitted by or on behalf of the physician and information received from other sources; and

(xiv) the appropriate health plan participation agreement, if applicable.

(d) A carrier shall report to a physician applicant or designee the status of a submitted initial credentialing application within a reasonable timeframe. The report shall include, but not be limited to, the application receipt date and, if incomplete, an itemization of all missing or incomplete items. A carrier may return an incomplete application to the submitter. A physician applicant or designee shall be responsible for all missing or incomplete items.

(e) A carrier shall notify a physician applicant of the carrier's credentialing committee's decision on an initial credentialing application within 4 business days of the decision. The notice shall include the committee's decision and the decision date.

(f) A physician, other than a primary care provider compensated on a capitated basis, who has been credentialed pursuant to this section shall be allowed to treat a carrier's insureds and shall be reimbursed by the carrier for covered services provided to a carrier's insureds effective as of the carrier's credentialing committee's decision date. A primary care physician compensated on a capitated basis who has been credentialed pursuant to this section shall be allowed to treat a carrier's insureds and shall be reimbursed by the carrier for covered services provided to the carrier's insured effective not later than the first day of the month following the carrier's credentialing committee's decision date.

(g) This section shall not apply to the credentialing and recredentilaing by carriers of psychiatrists or hospital-based physicians by carriers.

Section 2B. (a) The bureau's accreditation requirements related to credentialing and recredentiling shall not require a carrier to complete the credentialing or recredentialing process for hospital-based physicians.

(b) Except as provided in subsection (d), a carrier shall not require a hospital-based physician to complete the credentialing and recredentiailng process established pursuant to the bureau's accreditation requirements.

(c) A carrier may establish an abbreviated data submission process for hospital-based physicians. Except as provided in subsection (d), the process shall be limited to a review of the data elements required to be collected and reviewed pursuant to applicable regulations of the board of registration in medicine and shall not include primary source verification or a carrier's credentialing committee review.

(d) In the event that the carrier determines there is a need to further review a hospital-based physician's credentials due to quality of care concerns, complaints from insureds, applicable law or other good faith concerns, the carrier may conduct such review as is necessary to make a credentialing or recredentialing decision.

(e) Nothing in this section shall be construed to prohibit a carrier from requiring a physician to submit information or taking other actions necessary for the carrier to comply with the applicable regulations of

the board of registration in medicine.

(f) The Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans and Blue Cross and Blue Shield of Massachusetts shall work to develop standard criteria and oversight guidelines that may be used by carriers to delegate the credentialing function to providers. Such criteria and oversight guidelines shall meet applicable accreditation standards.

SECTION 33A. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following section:—

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

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

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

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

SECTION 34. The General Laws are hereby amended by inserting after chapter 176P the following chapter:—

CHAPTER 176Q.

LONG-TERM CARE INSURANCE.

Section 1. The purpose of this chapter shall be to promote the public interest and the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to promote flexibility and innovation in the development of long-term care insurance coverage.

Section 2. This chapter shall be known and may be cited as the Long-Term Care Insurance Act.

Section 3. As used in this chapter the following words shall, unless the context requires otherwise, have the following meanings:—

"Applicant", in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; or, in the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate", a certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery within the commonwealth.

"Commissioner", the commissioner of insurance.

"Group long-term care insurance", a long-tern care insurance policy that is delivered or issued for delivery within the commonwealth and issued to:—

(1) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by 1 or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; or

(2) any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(i) is composed of individuals all of whom are, or were, actively engaged in the same profession, trade or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance; or

(3) an association, or a trust, or the trustees of a fund established, created or maintained for the benefit of members of 1 or more associations; but, before advertising, marketing or offering the policy within the commonwealth, the association, or the insurer of the association, shall file evidence with the commissioner that the association has at the outset a minimum of 100 persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance; has been in active existence for at least 1 year; and have a constitution and bylaws that provide that:

(i) the association holds regular meetings not less than annually to further purposes of the members;

(ii) except for credit unions, the association collects dues or solicits contributions from members; and

(iii) the members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association shall be considered to have satisfied the organizational requirements, unless the commissioner makes a finding that the association does not satisfy those organizational requirements.

(4) A group other than those described in paragraphs (1), (2) and (3), subject to a finding by the commissioner that:—

(i) the issuance of the group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

(iii) the benefits are reasonable in relation to the premiums charged.

"Long-term care insurance", any insurance policy or rider: (1) advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; (2) for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services; and (3) provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders that provide directly, or supplement. long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term

care insurance contracts. Long-term care insurance shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for 1 or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision of this chapter, any product advertised, marketed or offered as long-term care insurance shall be subject to this chapter.

"Policy", any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery within the commonwealth by an insurer authorized to issue policies upon the lives of persons in the commonwealth or to provide accident and health insurance under chapter 175; a fraternal benefit society authorized under chapter 176; a nonprofit hospital service corporation authorized under chapter 176A, a nonprofit medical service corporation authorized under chapter 176E or a health maintenance organization authorized under chapter 176G.

(1) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(a) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(b) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or co-insurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security

Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

(c) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended;

(d) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph (e);

(e) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(f) The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(2) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

Section 4. No group long-term care insurance policy may be offered to a resident of the commonwealth under a group policy issued in another state to a group described in clause (4) of the definition of "group long-term care insurance" of section 3, unless the commonwealth or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the commonwealth has made a determination that the requirements set forth in said clause (4) have been met.

Section 5. (a) The commissioner shall promulgate regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies and certificates, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions,

elimination periods, requirements for replacement, offer of inflation protection, recurrent conditions and definitions of terms.

(b) A long-term care insurance policy shall not:—

(1) be cancelled, non-renewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(c)(1) A long-term care insurance policy, or certificate other than a policy or certificate thereunder, issued to a group as defined in clause (1) of the definition of "Group long-term care" of section 3 shall not use a definition of "pre-existing condition" that is more restrictive than the following: Pre-existing condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 24 months preceding the effective date of coverage of an insured person.

(2) A long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in clause (1) of the definition of "Group long-term care" of section 3 shall not exclude coverage for a loss or confinement that is the result of a pre-existing condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) Notwithstanding this subsection (c), an insurer may use an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, underwrite in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a pre-existing condition, regardless of whether it is disclosed on the application need not be covered until the waiting period described in subsection (2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in subsection (2).

(d) A long-term care insurance policy shall not be delivered or issued for delivery in this state if the policy:

(1) conditions eligibility for any benefits on a prior hospitalization requirement;

(2) conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(e) The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(f) Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in clause (1) of the definition of "Group long-term care" of section 3, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within 30 days of the return or denial.

(g)(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. In the case of producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form. In the case of a policy issued to a group defined in clause (1) of the definition of "Group long-term care" of section 3, an outline of coverage shall not be required to be delivered, provided that the information described in clauses (i) to (vi), inclusive, of paragraph (2) is contained in other materials relating to enrollment. Upon request, these other materials shall be made

available to the commissioner.

(2) The commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage. The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the principal exclusions, reductions and limitations contained in the policy or certificate;

(iii) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium; continuation or conversion provisions of group coverage shall be specifically described;

(iv) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(v) a description of the terms under which the policy or certificate may be returned and premium refunded;

(vi) a brief description of the relationship of cost of care and benefits; and

(vii) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(h) A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state shall include:

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions and limitations contained in the policy; and

(3) a statement that the group master policy determines governing contractual provisions and that the policy is available for viewing in the offices of the policyholder and will be copied for the certificate holder upon request at no cost.

(i) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

(j) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance

policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) any exclusions, reductions and limitations on benefits of long-term care;

(4) a statement indicating whether any long term care inflation protection option required by law is available under this policy;

(5) if applicable to the policy type, the summary shall also include:

(i) a disclosure of the effects of exercising other rights under the policy;

(ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) current and projected maximum lifetime benefits; and

(6) the policy summary listed above may be incorporated into a basic illustration or into the life insurance policy summary which is required to be delivered in accordance with applicable regulation.

(k) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

(l) If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

(1) provide a written explanation of the reasons for the denial; and

(2) make available all information directly related to the denial.

(m) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this chapter.

Section 6. (a) For a policy or certificate that has been in force for less than 6 months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(b) For a policy or certificate that has been in force for at least 6 months but less than 2 years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(c) After a policy or certificate has been in force for 2 years it is not contestable upon the grounds of misrepresentation alone; the policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d) A long-term care insurance policy or certificate shall not be field issued based on medical or health status. For purposes of this subsection the term "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the insurer may not recover the benefit payments if the policy or certificate is rescinded.

(f) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by section 132 of chapter 175. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Section 7. (a) Except as provided in subsection (b), a long-term care insurance policy shall not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a non-forfeiture benefit. The offer of a non-forfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the non-forfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial

increase in premium rates.

(b) When a group long-term care insurance policy is issued, the offer required in subsection (a) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group defined in clause (4) the definition of "Group long-term care" of section 3, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(c) The commissioner shall promulgate regulations specifying the type or types of non-forfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for non-forfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (a).

Section 8. The commissioner shall promulgate reasonable regulations in accordance with chapter 30A to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

Section 9. In addition to the penalties provided in chapters 175 and 176D, any insurer and any insurance producer found to have violated any requirement of this chapter or any regulations promulgated hereunder, relating to the regulation of long-term care insurance or the marketing of such insurance, shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

SECTION 34A. The General Laws are hereby amended by adding after chapter 268B the following chapter.

Chapter 268C. Physician and Pharmaceutical Manufacturer Conduct.

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

"Gift", a payment, entertainment, subscription, advance, services or anything of value, unless consideration of equal or greater value is received. This term shall not include a commercially

reasonable loan made in the ordinary course of business, anything of value received by inheritance, a gift received from a member of the reporting person's immediate family or from a relative within the third degree of consanguinity of the reporting person or of the reporting person's spouse or from the spouse of any such relative or prescription drugs provided to a physician solely and exclusively for use by the physician's patients.

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

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

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

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

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

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

"Pharmaceutical marketer", a person who, while employed by or under contract to represent a pharmaceutical manufacturing company, engages in pharmaceutical detailing, promotional activities or other marketing of prescription drugs in the commonwealth to any physician, hospital, nursing home, pharmacist, health benefit plan administrator or any other person authorized to prescribe, dispense or purchase prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A of chapter 112, a representative of such a distributor who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug or a retail pharmacist registered under section 37 of chapter 112 if such person is not engaging in such practices under contract with a manufacturing company.

"Pharmaceutical manufacturing company", an entity which is engaged in the production, preparation,

propagation, compounding, conversion or processing of prescription drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or an entity engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs. The term does not include a wholesale drug distributor licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of chapter 112.

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

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

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

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

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

SECTION 34B. The General Laws are hereby amended by inserting after chapter 176Q, added by section 34, the following chapter:—

CHAPTER 176Q.

COMMONWEALTH CARE HEALTH INSURANCE EXCHANGE.

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

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

"Board", board of the Commonwealth Care Health Insurance Exchange.

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

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.

"Commissioner", the commissioner of the division of insurance.

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

"Corporation", the Commonwealth Care Health Insurance Exchange.

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

"Eligible small groups," groups, any sole proprietorship, labor union, educational, professional, civic, trade, church, not-for profit or social organization or firms, corporations, partnerships or associations

actively engaged in business that on at least 50 percent of its working days during the preceding year employed at least 1 but not more than 50 employees.

"Exchange", Commonwealth Care Health Insurance Exchange.

"Health benefit plans," any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit hospital service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self- insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter i5A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

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

groups that purchase health benefit plans through the Exchange.

"Sub-exchange", authorized by the division of insurance to offer all health benefit plans that the Exchange may offer, including all health benefit plans with the Commonwealth Care Seal of Approval, to eligible small employers and individuals.

"Sub-contracted entities", a locally incorporated and governed organization, having had at least 10 years experience in the small business health insurance market, and which has served as a health insurance intermediary in the small group health insurance market under chapter 176J.

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

(b) The board of directors of the Corporation shall consist of: the commissioner of the division of health care finance and policy; the secretary for administration and finance; the executive director of the group insurance commission; the attorney general; 3 members to be appointed by the governor, 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 of whom shall be an employee health benefits plan specialist, and 1 of whom shall be an attorney specializing in employee benefit plans; and 2 members appointed by the attorney general, 1 of whom shall be a member of a labor union, and 1 of whom shall represent the interests of small businesses. An appointed member of the board shall not be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate 2 of the appointed members for a term of 3 years; 2 of the appointed members for a term of 4 years; and 1 of the appointed members for a term of 5 years. Thereafter, all appointments shall serve a term of 5 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for

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

(c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members of the board shall be necessary and sufficient for any action taken by the board. A vacancy in the membership of the board shall not impair the right of a quorum to exercise all the rights and duties of the Corporation. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.

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

(e) The board shall appoint an executive director, who shall supervise the administrative affairs and general management and operations of the Corporation and who shall also serve as secretary of the Corporation, ex officio. The executive director shall receive a salary commensurate with the duties of the office, and may be removed by the board for cause. The executive director may appoint other officers and employees of the Corporation necessary to the functioning of the Corporation. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the Corporation. The executive director shall, with the approval of the board: (1) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board; (2) employ professional and clerical staff as necessary, (3) report to the board on all operations under his control and supervision; (4) prepare an annual budget and manage the

administrative expenses of the Corporation; and (5) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

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

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

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

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

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

(ii) establish procedures for selecting an executive director;

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

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

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

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

organizations;

(vii) establish a plan directly or through one or more sub-contracted entities for publicizing the existence of the Exchange and the Exchange's and sub-exchanges' eligibility requirements and enrollment procedures;

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

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

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

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

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

(5) Contract with companies that provide third-party administrative and billing services for insurance products.

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

(7) Adopt by-laws for the regulation of its affairs and the conduct of its business.

(8) Adopt an official seal and alter the same at pleasure.

(9) Maintain an office at such place or places in the commonwealth as it may designate.

(10) Sue and be sued in its own name, plead and be impleaded.

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

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

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

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

(15) Do all things necessary to carry out the purposes of this chapter.

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

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

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

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

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

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

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

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

(1) preventive and primary care;

(2) emergency services;

(3) surgical benefits;

(4) hospitalization benefits;

(5) ambulatory patient benefits;

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

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

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

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

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

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

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

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

(2) that employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the Exchange and the amounts of the employer contributions, if any, to the such health plan, provided that, for the term of the agreement with the Exchange, the employer

agrees not to change or amend any such criteria or contribution amounts at anytime other than during a period designated by the Exchange for participating employer health plans;

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

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

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

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

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

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

Section 11. (a) The Exchange and sub-exchanges may apply a surcharge to individual premiums and

shall be used only to pay for administrative and operational expenses of the Exchange; but, the surcharge shall be applied uniformly to all health benefit plans offered through the Exchange.

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

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

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

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

(c) A person shall not be liable to the commonwealth, to the Corporation or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the Corporation except for willful dishonesty or intentional violation of the law; but the person shall provide reasonable cooperation to the Corporation in the defense of any claim. Failure of the person to provide reasonable cooperation shall cause him to be jointly liable with the Corporation. to the extent that the failure prejudiced the defense of the action.

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

(e) A civil action hereunder shall not be brought more than 3 years after the date upon which cause of

action thereof accrued.

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

Section 13. The Corporation shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its members, to the governor and to the state auditor, the reports to be in a form prescribed by the members, with the written approval of the state auditor. The members or that state auditor may investigate the affairs of the corporation, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the Corporation. The Corporation shall be subject to biennial audit by the state auditor.

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

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

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

SECTION 35. Item 9110-0100 of section 2 of chapter 177 of the acts of 2001 is hereby amended by

striking out the wording after "community care ombudsman services;" and inserting in place thereof the following wording:— provided further, that notwithstanding any general or special law to the contrary, there shall be a special commission to study the aging population and the future of long-term care in the commonwealth; provided further, that said commission shall be charged with evaluating options and making policy recommendations that can be used to develop legislation that will address the health care, housing, and pension needs of elders age 60 and older, as well as the status and needs of the long-term care workforce; provided further, that said commission shall examine eligibility requirements for medicaid and MassHealth for long-term care, including potential savings to the commonwealth by adjusting income requirements and asset requirements and the look-back period; provided further, that said commission shall also examine ways to market long-term care insurance and provide incentives to people to purchase long-term care insurance, including but not limited to proposed legislative and executive actions; provided further, said commission shall consist of the following members: the secretary of elder affairs or her designee, who shall serve ex officio; a representative of a labor organization representing long-term care workers; 1 representative from each of the following organizations: the Massachusetts Council of Home Care Aide Services, Mass Aging, Mass Home Care, the Alzheimer's Association, the Massachusetts Extended Care Federation, the American Association of Retired Persons, the Medicare Advocacy Project, the Home and Health Care Association of Massachusetts, the Massachusetts Assisted Living Facilities Association, the Mass Senior Action Council, Massachusetts Association of Older Americans, the Paraprofessional HealthCare Institute, the Massachusetts Chapter of the National Alliance of Caregivers, Health Care For All, the Massachusetts chapter of the National Association of Insurance and Financial Advisors, and the Massachusetts Association of Health Underwriters, and the Gerontology Institute at the University of Massachusetts at Boston; a representative of the National Academy of Elder Law Attorneys Massachusetts Chapter; a representative of the insurance industry who has experience in the insurance markets affecting long-term care who shall be appointed by the governor; and a representative of the business community who shall be appointed by the governor; provided further, that the members shall elect a chairperson of said commission; and provided further, that the commission shall release its first recommendations to the house and senate committees on ways and means not later than December 31, 2006.

SECTION 35A. Section 2 of chapter 45 of the acts of 2005 is hereby amended by striking out items 4000-0890 and 4000-0891.

SECTION 35B. Item 4510-0600 of said section 2 of said chapter 45 is hereby amended by adding the following words:— ; provided further, that $140,000 shall be made available for an interdepartmental service agreement between the department of public health and the University of Massachusetts at Lowell to support research activities which investigate the association between ethnic diversity nd childhood asthma incidence; and provided further, that not more than $360,000 shall be expended by the department for outreach and education grant programs including, but not limited to, programs servicing underserved populations."

SECTION 36. The secretary of health and human services shall seek an amendment to the MassHealth Demonstration Waiver granted by the United States Department of Health and Human Services under section 1115(a) of the Social Security Act and authorized by chapter 203 of the acts of 1996 to implement this act and is hereby further authorized and directed to seek to obtain maximum federal reimbursement for any provision of this act for which federal financial participation is available. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver application.

SECTION 37. The division of health care finance and policy shall file a detailed report to the joint committee on health care financing on the feasibility of requiring all residents of the commonwealth to obtain employer-based health insurance. The report shall consider the effect of such a law, if any, on: (1) health insurance premiums charged by private insurers; (2) the number of residents without insurance; (3) the costs of health insurance for employers; (4) utilization and costs of uncompensated care pool services; (5) the commonwealth's fiscal impact; and (6) any other pertinent issues relating to the feasibility and appropriateness of such a law. The report shall be filed not later than February 1, 2006.

SECTION 38. (a) Notwithstanding any general or special law to the contrary, but subject to subsection (b) of this section and section 40 of this act, for the purposes of paying providers under chapter 118E of the General Laws, effective for services beginning not later than January 1, 2006, the division shall

transition to the payment systems and fee schedules used by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program under Title XVIII of the Social Security Act, including, for purposes of payment for covered hospital services, all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital, including, but not limited to, annual increases in the Medicare hospital market basket index. The division shall modify the payment systems and fee schedules to account for the following:

(1) the differences between the programs specified in said chapter 118E and the Title XVIII Medicare program, including the services and benefits covered, and, for purposes of calculating the payment rates for covered hospital services, the division shall use a grouper and DRG relative weights that have been determined, in consultation with the MassHealth Payment advisory committee, pursuant to section 42 of this act, to reimburse providers at a rate no less than the rate providers are reimbursed by Medicare;

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

fiscal year 2006 rates for the period from October 1, 2005 through the effective date of the implementation of the adjusted hospital fiscal year 2006 rates; and provided further, that once such systems and fee schedules are fully implemented, the division shall ensure that the rates paid for covered services under said chapter 118E shall not thereafter be less than the rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section.

(3) notwithstanding paragraphs (1) and (2), the division shall not increase rates for any provider that is required by this subsection to be held harmless at its current reimbursement level until such time as increases in its rates would be warranted by application of the Medicare systems and fee schedules, as adjusted by this subsection.

(b) Notwithstanding any general or special law to the contrary, for the purposes of paying community health centers for covered services under chapter 118E of the General Laws, effective for services beginning not later than October 1, 2006, the division shall pay community health centers a base rate that shall be no less than the Medicare Federally Qualified Health Center rate as required under 42 USC section 13951(a)(3), which the division shall adjust for wage differences, and to which the division shall add payments for additional services not included in the base rate including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion services. For the purposes of this section, a community health center shall be defined as a clinic that provides comprehensive ambulatory services and that (1) is licensed as a freestanding clinic by the Massachusetts department of public health pursuant to section 51 of chapter 111 of the General Laws (2) meets the qualifications for certification, or provisional certification, by the division of medical assistance and enters into a provider agreement pursuant to 130 CMR 405.000; (3) operates in conformance with the requirements of 42 U.S.C. s254(c); and (4) files cost reports as requested by the division of health care finance and policy.

(c) In updating rates of payment under chapter 118E of the General Laws and making the modifications to the Medicare payment systems and fee schedules required by this section, the division shall adopt the advice and counsel, and give due consideration to the recommendations of the MassHealth Payment advisory board established pursuant to section 42.

(d) All rates of payment for acute and non-acute care hospitals, as defined under section 1886(d)(1)(B)(ii) or section 1886(d)(l)(B)(iv)(I) of the Social Security Act, shall be reasonable and adequate to meet

the costs which shall be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards and to assure that individuals have reasonable access, taking into account geographic location and reasonable travel time, to inpatient and outpatient hospital services of adequate quality. The division shall make adjustments to the calculation of the federal upper payment limit in order to maximize the amount that may be paid to providers under the upper payment limit. These adjustments shall include, but not be limited to; using the Medicaid paid claims file as the data source; changing the base year for the Medicare payment to charge ratio; changing the payment inflation and charge increase assumptions used to update base year data to current year data; and including in the calculation out-of-state hospital providers who receive payments from the Massachusetts Medicaid program.

(e) Payments made for the purposes of this section shall be expended from the Health Care Access and Investments Trust Fund established pursuant to section 2OOO of chapter 29 of the General Laws.

SECTION 39. (a) Notwithstanding any general or special law to the contrary, in any year in which the uncompensated care pool payment to cost ratio of an acute care hospital or community health center, as calculated under subsection (b) falls below 95 per cent, the division of health care finance and policy shall calculate and make the additional payments to the affected acute care hospital or community health center that are required to maintain its uncompensated care pool payment to cost ratio at 95 per cent. The commonwealth shall increase its share of the uncompensated care trust fund by an amount equal to the amount needed to fund the additional payments to all affected acute care hospitals and community health centers under this subsection.

(b) The division shall calculate the uncompensated care pool payment to cost ratio for 1 each acute care hospital and community health center for each pool year by dividing (1) the total pool payments made to such acute care hospital or community health center pursuant to all general and special laws effective for the relevant period, without regard, however, to any additional amounts paid or to be paid to the hospital or community health center for any period by virtue of subsection (a) of this section, by (2) the total allowable uncompensated care costs of the hospital or community health center, as defined in section 18 of chapter 118G of the General Laws, for the relevant period.

(c) Rates of payment for providers of hospital services as calculated pursuant to section 38 shall apply to payments to the providers for services paid from the uncompensated care pool pursuant to section 18 of chapter 118G of the General Laws.

SECTION 40. Notwithstanding any general or special law to the contrary and notwithstanding any regulations of the division of health care finance and policy or the division of medical assistance to the contrary, effective July 1, 2006, the fees payable under programs administered by the division of medical assistance for physician services shall be subject to the following:

(1) For each fiscal year, the fee schedule for physician services delivered on or after July 1 of that fiscal year shall consist of the fees for physician services in effect at the end of the immediately preceding fiscal year, subject to an annual upward inflation adjustment for each fee as determined by the commissioner of medical assistance. The annual adjustment shall be at least equal to any upward adjustment in the United States Medicare Economic Index for physician services as defined in section 1842 (i) (3) of the Social Security Act.

For the calculation of the fee schedule for physician services for fiscal years beginning on July 1, 2006, and July 1, 2007, each of the fees contained on the schedule of fees for physician services in effect at the end of the immediately preceding fiscal year shall, in addition to the adjustments provided for in subparagraph (a), be further adjusted upward by an amount equal to not less than 7 per cent of the fees in effect for the previous fiscal year.

(3) This section shall apply to physician services rendered under contracts authorized by section 12 of chapter 118E of the General Laws unless otherwise specifically agreed to in contract by the providers. Pursuant to regulations to be promulgated by the division of medical assistance by January 1, 2006, the division of medical assistance shall pay for, or assure that all of its contractors responsible for paying for physician services shall pay for, all office procedures appropriately provided by a physician practice during a single office visit to a person eligible to receive healthcare services under programs administered by the division of medical assistance.

(d) All payments made for the purposes stated in this section shall be expended from the Health Care Access and Investments Fund established pursuant to section 2OOO of chapter 29 of the General Laws.

SECTION 41. (a) There shall be a quality and cost management initiatives commission, hereinafter in this section the commission, which shall perform the responsibilities set forth in subsection (b). The commission shall consist of the secretary of health and human services or his designee and 13 members appointed by the governor as provided in this subsection. The governor, after consultation with the relevant interests, shall appoint 1 member to represent the interests of the medical school in the commonwealth, 2 members to represent the interests of physician group practices, 1 member to represent the interests of academic medical centers, 1 member to represent the interests of community hospitals, 1 member to represent the interests of carriers licensed under chapters 175 or 176G of the General Laws and 1 member to represent the interests of the employer community. The governor shall appoint 1 person each from nominations submitted by the following organizations: the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, and Blue Cross Blue Shield of Massachusetts and the Alliance of Massachusetts Safety Net Hospital.

(b) The commission shall consider and report to the joint committee on health care financing and the house and senate committees on ways and means, no later than September 15, 2006, its recommendations for creating mechanisms by which payments to acute hospitals and physicians under chapter 118E of the General Laws may incorporate financial incentives for the providers to provide quality care in a more efficient and effective manner. In developing its report, the commission shall consider elements of pay for performance mechanisms, so-called, including various measures related to the structure, process and outcomes of medical care delivery and the types of financial incentives that are most likely to impact positively on the overall quality and cost of care provided to persons eligible for the various programs administered pursuant to said chapter 118E. The commission shall consider the feasibility of providing targeted resources or financial incentives, in addition to the amounts and annual inflationary adjustments that otherwise would be paid for hospital and physician services under said chapter 118E, to promote pay for performance mechanisms, so-called, in the expectation that the commonwealth will realize savings through improvements in quality and utilization of services covered by such programs, as a result of the incentives. In developing its recommendations, the commission shall consider the types of pay for performance measures used by private payors, but shall focus hospital

measures on those endorsed and supported by governmental programs, including but not limited to those developed by the Hospital Quality Alliance and endorsed by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services; but, hospital measures shall not be utilized that have not been adopted as a voluntary consensus standard for hospital care by the National Quality Forum. The commission shall consider the suitability of available measures for use with hospitals and physicians in the commonwealth; the cost associated with developing and implementing new measures; the data needed to devise and apply such measures as it may recommend; the differential ability of physicians and acute hospitals to generate necessary data; the time frames within which such providers may reasonably be expected to generate data needed to apply such measures; the cost to the providers to generate such data; the availability, or the feasibility of developing, financing mechanisms to facilitate the ability of such providers to provide data and to implement pay for performance measures; and such other factors as the commission may deem material to its report and recommendations.

SECTION 42. (a) There shall be a MassHealth payment policy advisory board. The board shall be composed of 12 members of the health care industry who are knowledgeable in health care finance and economics. The governor shall appoint 1 co-chairman nominated by the speaker of the house, 1 co-chairman nominated by the president of the senate, 1 member nominated by the Massachusetts Hospital Association, 1 member nominated by the Massachusetts Medical Society, 1 member nominated by the Massachusetts Extended Care Federation, 1 member nominated by the Home and Health Care Association of Massachusetts, 1 member nominated by the Massachusetts League of Community Health Centers, 1 member nominated by the Massachusetts Medicaid Policy Institute, 1 member nominated by the Associated Industries of Massachusetts, 1 member nominated by the Massachusetts Association of Health Plans, 1 member nominated by the Alliance of Massachusetts Safety Net Hospitals, 1 member nominated by the Massachusetts Association of Behavioral Health Systems and 1 member of the community.

(b) The board shall have the following powers and duties:

(1) It shall obtain from the division all data and analysis required to fully meet its charge pursuant to the Health Care-Access and Investments Trust Fund established in section 2OOO of chapter 29 of the

General Laws and sections 38 and 39 of this act and to obtain further data and analysis from the division of health care finance and policy as authorized in chapter 118G of the General Laws;

(2) It shall review and evaluate rates and payment systems proposals by the division and recommend Title XIX rates and rate methodology that are consistent with the Health CareAccess and Investments Trust Fund and sections 38 and 39 of this act and with the level of funding available as authorized by the general appropriation act; but the division shall provide the board with the appropriate information not later than 45 days before the proposals are adopted into regulation; and

(3) It shall report to the joint committee on health care financing and the house and senate committees on ways and means semi-annually to coincide with the state budget hearings and development.

(c) The executive office of health and human services shall provide the board with staff from the division of health care finance and policy necessary to complete needed research and analysis and enable the committee to make effective recommendations. Notwithstanding any general or special law to the contrary, all expenditures under this section shall, subject to appropriation, be funded from the Health Care Access and Investments Trust Fund; but, not less than 90 days before implementing any of the payment policies established under this section, the division shall provide a detailed plan of implementation of the policies to the joint committee on health care finance and to the house and senate committees on ways and means.

SECTION 43. Notwithstanding any general or special law to the contrary, effective September 1, 2006, each state and community college shall require that all students enrolled in 9 or more credits shall submit written documentation evidence of adequate medical insurance coverage. A list of the names, addresses, and social security numbers of all students indicating any form of MassHealth insurance coverage shall be forwarded to the division of medical assistance for evaluation of alternative insurance options. The list shall be subject to privacy standards pursuant to Public Law 104-191, and the Health Insurance Portability and Accountability Act of 1996.

The division may assist in the purchase of group health insurance, including insurance offered through a college or university, on behalf of an eligible MassHealth member; if the division has determined that the purchase of the insurance is cost-effective and will be provided at no cost to the commonwealth. The

division shall deny liability to any adult who refuses to enroll in other available insurance.

SECTION 44. (a) Notwithstanding any general or special law to the contrary, a hospital that is eligible for improved provider rates pursuant to section 38 and 39 shall, not later than December 1 of each year, submit to the department of public health the hospital's plan for compliance with the common program requirements of the duty hours reductions for resident-physicians as mandated by the Accreditation Council for Graduate Medical Education, ACGME, for interns, residents and fellows for the following year from January 1 to December 31.

(b) The plan submitted shall be formatted so that the following data is easily accessible and understandable, however, the data may be aggregated or redacted, as needed to protect confidentiality:

(1) The schedule for each required rotation within each accredited program, indicating the number of hours each week that resident-physicians are scheduled to perform direct patient care.

(2) The maximum, minimum and average number of days each month that the resident-physicians in each ACGME-accredited program are scheduled for "In house call."

(3) The number of days each month the resident-physician is scheduled to be assigned "At home call."

(4) A list of any individual program citations issued by ACGME during the prior academic year for non-compliance with the duty-hours restrictions.

(5) Copies of the written policies and procedures mandated by the ACGME Program requirements that are distributed to resident-physicians and faculty. Each individual program within an institution shall submit its own duty-hours policy requirements.

(6) A description of the back-up support systems provided by the institution in cases where patient care responsibilities are unusually difficult or prolonged or where resident-physician fatigue may be sufficient to jeopardize care. Each individual program within an institution shall submit its own back-up support policies unless a single policy covers all programs.

(7) A description of the measures instituted to reduce the occurrence of resident-physician fatigue, including, but not limited to, educational material presented to students and faculty.

(e) A hospital that fails to submit the information required under this section shall be assessed an administrative fine by the department of up to 5 per cent of the provider payments to which the hospital

would otherwise be entitled under sections 35 and 36. Except for this administrative fine, a hospital, institution or person shall not be held liable in any civil or criminal action or other proceeding for any failure to comply with a voluntary safe staffing plan submitted under this section or for any failure to comply with this section.

SECTION 45 . (a) Notwithstanding any general or special law to the contrary, there shall be within the department of public health an advisory committee for resident-physicians. The committee shall be comprised of 11 members to be appointed by the commissioner of public health, 1 of whom shall be a representative from the Massachusetts Medical Society, 1 of whom shall be the chancellor of the University of Massachusetts Medical School, 1 of whom shall be the executive director of the board of registration in medicine or her designee, 2 of whom shall be representatives of the Massachusetts Hospital Association, 1 of whom shall be a representative of the committee of interns and residents/SEIU, 1 of whom shall be a resident-physician from an academic medical institution that does not have representation by the committee of interns and residents' SEIU, 1 of whom shall be a resident-physician from a community hospital, 1 of whom shall be the director of a graduate medical education office at a hospital located in the commonwealth, 1 of whom shall be a consumer and 1 of whom shall be the executive director of the Betsy Lehman Center for Patient Safety and Medical Error Reduction who shall serve as the chairperson of the committee. The members of the committee shall serve without compensation. Appointments shall be made within 90 days after the effective date of this act. The committee shall dissolve after completion of the reports required in this section.

(b) The committee shall make an investigation and study into the working conditions of resident-physicians in the commonwealth. Based on the study, the department shall adopt rules and regulations for the purpose of establishing a model work environment that promotes quality of care and patient and resident-physician safety. The study shall consider, but shall not be limited to: limiting resident-physicians to not more than a total of 80 hours per week and not more than 24 hours per shift, including time for the transition of patient care information; limiting resident-physicians who are assigned to patient care responsibilities in an emergency department to not more than 12 continuous hours; requiring resident-physicians to have a nonworking period of not less than 16 hours following a 24-hour shift and

at least 10 hours between other scheduled shifts; requiring at least 24 consecutive hours free every 7 days and requiring at least 1 full 48-hour period off per month; limiting the resident-physician to overnight, on-call duty in the hospital not more frequently than 1 night in 3; accommodations that can be made in any recommended time limitations for a state of emergency declared by the commonwealth that applies with respect to that hospital or for an emergency situation when a resident-physician is providing critical physician-care to an individual patient and cannot be replaced; requirements for each hospital to inform resident-physicians of their rights under any rules and regulations promulgated by the department; enforcement of such rules and regulations including, but not limited to, the posting of maximum hours limitations in all departmental offices, informing all resident-physicians of their rights to report any violations of the regulations, whistleblower protections and the use of surveys of resident-physicians and reporting by hospitals to determine compliance with rules and regulations promulgated under this section; and requiring that resident-physicians and hospital supervisors be informed of the effects of acute and chronic sleep deprivation both on the resident-physicians and on the quality of patient care.

(c) Notwithstanding any general or special law to the contrary, the committee shall make an investigation and study into appropriate penalties for violations of any rules and regulations promulgated pursuant to subsection (a). Based on the study, the department shall adopt rules and regulations to establish a model work environment that promotes quality of care and patient and resident-physician safety. The study shall consider, but shall not be limited to: identifying a position within the department responsible for investigating all complaints of violations of any rules and regulations promulgated by the department pursuant to subsection (b) and the use of monetary and nonmonetary penalties to maximize improvement of patient safety.

(d) Notwithstanding any general or special law or rule or regulation to the contrary, the committee shall make an investigation and study into the process by which complaints shall be filed with the department. The study shall include, but shall not be limited to, allowing the filing of anonymous complaints, complaints by resident-physicians, complaints by consumers and complaints by other health care professionals.

(e) The results of the investigation and studies required by this section shall be presented to the

department not later than 270 days after the effective date of this act.

(f) For the purposes of this section, the term "resident-physician" shall include a medical intern, resident or fellow enrolled in an ACGME accredited graduate medical education program.

SECTION 46. Each city or town shall offer all employees the opportunity to purchase health care insurance through a plan administered by the city or town; pursuant to chapter 32B of the General Laws. Nothing in this section shall replace or void terms or agreements within an existing collective bargaining agreement, nor prohibit any public employee union from being able to collectively bargain health insurance benefits in the collective bargaining agreement with any city or town. An employee who declines to obtain such insurance and receives services through the uncompensated care pool or Medicaid shall be considered a "voluntarily uninsured employee" for purposes of chapter 118G of the General Laws.

SECTION 47. Notwithstanding any general or special law to the contrary, any ambulatory surgical center, so-called, that meets the definition of clinic under section 52 of chapter 111 of the General Laws, shall not require a determination of need by the department of public health under section 51 of said chapter 111 or sections 25B to 25G, inclusive, of said chapter 111 and any ambulatory surgical center, so-called, that meets the definition of clinic under section 52 of said chapter 111 or a single specialty hospital, so-called, shall be considered to be in compliance with the conditions of licensure under said section 51 of said chapter 111 if it is accredited by the joint commission on accreditation of health care organizations, JCAHO, or its equivalent; provided, however, that any ambulatory surgical center that is in existence as July 1, 2005, shall be certified by Medicare and any ambulatory surgical center that is established after July 1, 2005 shall be certified by Medicare and shall still be in substantial compliance with any applicable licensure and regulatory requirements so promulgated by the department of public health that are not specifically contained within the JCAHO or an equivalent accreditation; provided further, that the ambulatory surgical center or single specialty hospital shall also meet the following conditions: (1) agree to contract with the executive office of health and human services to participate as a MassHealth provider; (2) agree to establish and maintain a percentage of gross patient service revenues allocated to free care, the percentage shall be based on the amount provided by a similarly

situated acute care hospital in the same service areas the center or specialty hospital; and (3) develop procedures to deal with patients needing emergency level services following the delivery of services, which may include but not be limited to contracting with an acute care hospital with an emergency department within geographical proximity to said center or specialty hospital. The department shall promulgate regulations to enforce this section and any agreement made by the center or specialty hospital concerning the provisions of MassHealth and free care.

SECTION 48. (a) There shall be established within the division of insurance, a small group review board to be chaired by the commissioner of insurance.

(b) The board shall: (i) conduct an analysis of existing health benefits currently mandated by state law; (ii) not less than 1 year after implementation, review and make recommendations relative to the operation of the reinsurance program established by this act; (c) recommend additional steps to further stabilize premiums for small and individual group insurance; (d) conduct an actuarialy sound study of the impact and benefits of expanding the small group market from 50 to 75 employees; and (e) make such additional recommendations as it deems appropriate for promoting competition or other steps to contain premium costs while ensuring that the interest of the health insurance consumer is pre-eminent. The board shall consist of 10 members, who are citizens of the commonwealth, to be appointed by the governor, 1 of whom shall represent businesses or employers; 2 of whom shall represent the health care industry, 1 of whom shall be selected from the Massachusetts Association of Health Plans, 1 of whom shall represent the Massachusetts Association of Health Underwriters, 1 of whom shall represent the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be selected by Blue Cross and Blue Shield of Massachusetts, and 1 of whom shall be selected from the Massachusetts Hospital Association. One person shall represent a consumer advocacy organization, who shall be selected from Health Care for All and 1 person shall be a person with a background actuarial work or health policy and economics.

(c) In considering its recommendations, the board shall consult and use, where appropriate, standards established by national accreditation organizations. Notwithstanding the foregoing, the board shall not be bound by said standards established by such organizations, but wherever the board proposes

standards different from said national standards, it shall state the reason for such variation, and take into consideration any projected compliance costs for such variation.

(d) The board shall make its report relative to subsection (a) to the joint committee on health care financing not later than December 1, 2006 and shall make its remaining reports not later than December 31, 2007.

SECTION 49. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until January 1, 2007, or until the small group review board, established pursuant to section 47 files its recommendations to the joint committee on health care financing, whichever occurs first. Joint committees of the general court and the house and senate committees on ways and means shall refer all mandated health benefits bills referred to them during the 2005 to 2006 session of the general court, to the small group review board and shall take no further action on them during that term.

SECTION 50. (a) The division of health care finance and policy and the executive office of health and human services, in consultation with other relevant state agencies, shall conduct a comprehensive review and evaluation of all existing mandated health benefits, including, but not limited to, those mandated benefits established pursuant or defined in section 38C of chapter 3, chapters 175, 176A, 176B and 76G, respectively, and shall report not later than June 30, 2006, together with any recommendations for amendment or repeal, to the joint committee on health care financing and to the small group review board established pursuant to section 43.

(b) The small group review board shall hold one or more public hearings on the report required pursuant to subsection (a), and shall make its recommendations regarding legislation, if any, not later than December 1, 2006, to the joint committee on health care financing.

(c) Wherever it can be ascertained, the party or organization on whose behalf a mandated health benefit law was enacted shall provide the division of health care finance and policy with any cost or utilization data that they have. All interested parties supporting or opposing the retention of any mandated health benefit law shall provide the division of health care finance and policy with any information relevant to the division's review. The division shall enter into interagency agreements as necessary with the

division of medical assistance, the group insurance commission, the department of public health, the division of insurance, and other state agencies holding utilization and cost data relevant to the division's review under this section. Such interagency agreements shall ensure that the data shared under the agreements is used solely in connection with the division's review under this section, and that the confidentiality of any personal data is protected. The division of health care finance and policy may also request data from insurers licensed or otherwise authorized to transact accident or health insurance under chapter 175, nonprofit hospital service corporations organized under chapter 176A, nonprofit medical service corporations organized under chapter 176B, health maintenance organizations organized under chapter 176G, and their industry organizations to complete its analyses. The division of health care finance and policy may contract with an actuary, or economist as necessary to complete its analysis. The report shall include, at a minimum and to the extent that information is available, the following:

(1) the financial impact of each currently mandated health benefit, including the extent to which the insurance coverage has increased or decreased the cost of the treatment or service over the past 5 years, the extent to which the mandated coverage increased the appropriate or inappropriate use of the treatment or service over the past 5 years, the extent to which the mandated treatment or service served as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage affected the number and types of providers of the mandated treatment or service over the past 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of large employers, small employers, employees and non-group purchasers, the direct and indirect benefits and savings to large employers, small employers, employees and non-group purchasers, the effect of the mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth;

(2) the medical efficacy of the mandated health benefit, including the impact of the benefit to the quality of patient care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or service; and

(3) if the current benefit mandated coverage of an additional class of practitioners, the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those previously covered and the methods of the appropriate professional organization that assures clinical proficiency.

SECTION 51. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall not make any changes to the financing, operation or regulation of, or contracts pertaining to, the provision of behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, Office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI S-CHIP, and any MassHealth expansion population served under Section 1115 waivers, so-called, nor shall it recommend or procure, by request for response or otherwise, any such changes, nor shall it seek approval from the Centers for Medicare, and Medicaid Services for any such changes, until it has submitted a report outlining the proposed changes, together with reasons therefor and an explanation of the benefits of such changes, to the joint committees on mental health and substance abuse and health care financing, and in no case before February 15, 2006.

SECTION 52. Notwithstanding any general or special law to the contrary, during fiscal year 2007 and subsequent years, the secretary of the executive office of health and human services shall implement actuarially sound rates to the maximum extent allowable, which shall reimburse certain publicly-operated entities operated by the Cambridge public health commission and the Boston public health commission, respectively, providing Title XIX reimbursable services, directly or through contracts with hospitals under an agreement with the executive office of health and human services, at levels consistent with their supplemental payments in fiscal year 2006, as specified in section 16 of chapter 45 of the acts of 2005.

SECTION 53. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall create a 2-year pilot program for smoking and tobacco use cessation treatment and information to include within its MassHealth covered services. Smoking and tobacco use cessation

treatment and information benefits shall include nicotine replacement therapy, other evidence-based pharmacologic aids to quitting smoking, and accompanying counseling by a physician, certified tobacco use cessation counselor, or other qualified clinician. The executive office shall report annually on the number of enrollees who participate in smoking cessation services, number of enrollees who quit smoking, and Medicaid expenditures tied to tobacco use by Medicaid enrollees. The comptroller shall transfer $7,000,000 from the Health Care Security Trust, established by section 1 of chapter 29D of the General Laws, to the General Fund in fiscal year 2007 and fiscal year 2008 to fund the program.

SECTION 54. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 1,600 people, for a maximum total of 15,600 enrollees, in the CommonHealth program, so-called, funded in item 4000-0430 in section 2 of chapter 45 of the acts of 2005.

SECTION 55. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 250 people, for a maximum total of 1,300 enrollees, in the Family Assistance HIV positive program, so-called, funded in item 4000-1400 in section 2 of chapter 45 of the acts of 2005.

SECTION 56. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 16,000 people, for a maximum total of 60,000 enrollees, in the MassHealth Essential program, so-called, funded in item 4000-1405 in section 2 of chapter 45 of the acts of 2005.

SECTION 56A. Notwithstanding section 5 of chapter 176J, of the General Laws, section 3 of chapter 176M of the General Laws, section 2 of chapter 176N of the General Laws or any other general or special law to the contrary, a carrier shall not impose a pre-existing condition exclusion or waiting period for more than 3 months following an individual's effective date of coverage with respect to Trade Act/Health Coverage Tax Credit Eligible Persons.

SECTION 57. The secretary of health and human services shall seek to obtain federal S-CHIP

reimbursement, pursuant to Title XXI, for all persons eligible. To the extent S-CHIP funds are not available for all eligible programs, the secretary shall first seek S-CHIP reimbursement for Title XXI eligible programs prior to claiming S-CHIP reimbursement for Title XIX eligible programs. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of federal S-CHIP reimbursement.

SECTION 57A. Notwithstanding any general or special law to the contrary, not later than 10 days after the effective date of this act, the comptroller shall transfer $162,575,000 from the Commonwealth Stabilization Fund, established pursuant to section 2H of chapter 29 of the General Laws, to the Health Care Access and Investments Trust Fund established in section 2OOO of said chapter 29.

SECTION 57B. Notwithstanding any general or special law to the contrary, not later than 10 days after the effective date of this act, the comptroller shall transfer the unexpended balances from items 4000-0890 and 4000-0891 of section 2 of chapter 45 of the acts of 2005 to items 7002-0900 and 7002-0901, respectively.

SECTION 57C. Notwithstanding any general or special law to the contrary, the comptroller shall transfer $5,000,000, effective December 31, 2005, from the Health Care Access and Investments Trust Fund to the Massachusetts Technology Park Corporation established in section 3 of chapter 40J of the General Laws, to support the initial implementation of its computerized physician order entry system initiative and other activities designed to save lives, reduce health care costs and increase economic competitiveness for the citizens of the Commonwealth.

SECTION 57D. Section 2OOO of chapter 29 of the General Laws shall expire on October 30, 2009 and any unexpended amounts in the Health Care Access and Investments Trust Fund shall be credited to the General Fund.

SECTION 57E. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval, effective immediately, to eliminate enrollment caps for the programs authorized in section 9C of chapter 118E of the General Laws.

SECTION 57F. Notwithstanding any special or general law to the contrary, in fiscal year 2006, $90,000,000 shall be made available from the Health Care Access and Investment Trust Fund to pay for an increase in Medicaid rates paid to hospitals and community health centers. An additional $16,000,000 shall be made available for an increase in rates for physicians. All rate increases shall be in accordance with provisions of the fund.

SECTION 57G. Notwithstanding any special or general law to the contrary, in fiscal year 2007, $90,000,000 shall be made available from the Health Care Access and Investment Fund to pay for an increase in Medicaid rates paid to hospitals and community health centers. An additional $16,000,000 shall be made available for an increase in rates for physicians. All rate increase shall be in accordance with provisions of the fund.

SECTION 58. There shall be a Massachusetts health disparities council, located within, but not subject to the control of, the executive office of health and human services. The council shall make recommendations regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the commonwealth. The disparities shall include, but not be limited to breast, cervical, prostate and colorectal cancers, stroke and heart attack, heart disease, diabetes, infant mortality, lupus, HIV/AIDS, asthma and other respiratory illnesses. The council shall address diversity in the health care workforce, including but not limited to, doctors, nurses and physician assistants and shall make recommendations on methods to increase the health care workforce pipeline. The council shall also make recommendations on other matters impacting upon and relevant to health disparities including but not limited to the environment and housing.

The council shall initially consist of the members of the special legislative commission created in section 57 of chapter 65 of the acts of 2004. At the end of the first fiscal year following the effective date of this act, the council membership shall be re-determined by the speaker of the house of representatives, the president of the senate and the governor.

The council shall file an annual report at the end of each fiscal year with the office of the governor, the clerk of the house of representatives, and the clerk of the senate. The report shall include, but not be limited to, recommendations for designing, implementing and improving programs and services, and

proposing appropriate statutory and regulatory changes to reduce and eliminate disparities in access to health care services and quality care, and the disparities in medical outcomes in the commonwealth, and to address diversity and cultural competency in the health care workforce, including but not limited to, doctors, nurses and physician assistants.

SECTION 58A. During pool fiscal years 2006 and 2007, the provisions of 114.6 CMR 10.00, 114.6 CMR 11.00 and 114.6 CMR 12.00, in effect as of September 15, 2005, shall remain in force for the uncompensated care pool established under chapter 118G of the General Laws or any successor program.

SECTION 58B. The secretary of the executive office of health and human services shall conduct a study to determine the costs of allowing primary care givers to obtain MassHealth benefits if they care for on a full-time basis, elderly parents or immediate family members who are disabled. The secretary shall submit the report to the senate president, senate minority leader, chairman of the senate ways and means committee, speaker of the house of representatives, house minority leader and chairman of the house ways and means committee no later than July 1, 2006.

SECTION 58C. The division of medical assistance shall conduct a pilot program to provide explanation of benefit receipts to a sample of MassHealth beneficiaries following services rendered.

SECTION 58D. The commissioner of the division of medical assistance, the secretary of the executive office of elder affairs, the commissioner of the group insurance commission and the commissioners of state agencies participating in the Massachusetts prescription drug fair pricing program established by chapter 118H of the General Laws shall take all steps necessary to enable the commonwealth to participate in joint prescription drug purchasing agreements with other states and other health benefit plans. Such steps shall include:

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

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

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

SECTION 58E. (a) The General Court finds that the National Legislative Association on Prescription Drug Prices is a nonprofit organization of legislators formed for the purpose of making prescription drugs more affordable and accessible to citizens of the member states, including the commonwealth. The General Court further finds that the activities of the Association provide a public benefit to the people of the commonwealth.
(b) Three members of the senate, including 1 member of the minority party, shall be appointed directors of the Association by the senate president, and 3 members of the house of representatives, including 1 member of the minority party, shall be appointed directors of the Association by the speaker of the house. Directors so appointed shall serve until new members are appointed.
(c) The directors of the Association shall report to the house and senate committees on ways and means and the joint committees on health care and insurance on or before January 1 of each year with a summary of the activities of the Association, and any findings and recommendations for making prescription drugs more affordable and accessible to citizens of the commonwealth.

SECTION 58F. Notwithstanding any general or special law to the contrary, on June 30, 2006, the state comptroller shall transfer $1,500,000 from the Commonwealth Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for the purposes of educating and increasing the awareness of uninsured residents of the commonwealth as to their options for becoming insured through the Corporation.

SECTION 58G. Notwithstanding any general or special law to the contrary, on June 30, 2006, the state comptroller shall transfer $4,500,000 from the Commonwealth Stabilization Fund to the Commonwealth Care Health Insurance Exchange Corporation established under chapter 176Q for administrative and operating expenses of the Corporation.

SECTION 58H. The commissioner of public health, or his designee, is hereby requested to study the impact of the Federal Volunteer Protection Act of 1997 on health care volunteers in the Commonwealth. The commissioner is requested to review ways in which the commonwealth may act to provide legal counsel and defense to volunteers who may be eligible for the protections afforded in the Volunteer Protection Act. The commissioner is requested to report back to the joint committee on health care with his recommendations by December 31, 2006.

SECTION 58I. A managed care organization, as defined in 130 CMR 501.001, which maintains National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line, shall be considered compliant by the office of Medicaid for all standards within the categories for which the Managed Care Organization (MCO) has been surveyed and determined to meet all standards. Accredited MCO's will be required to provide quarterly, semi-annual and annual reporting as required per contract.

SECTION 58J. The initial regulations to be adopted under subsection (e) of section 45B, of chapter 112, under section 11A of this act, shall be adopted.

SECTION 58K. The commissioner of public health, or his designee, shall study the impact of the federal Volunteer Protection Act of 1997 and the Free Clinics Federal Tort Claims Act Medical Malpractice Program on health care volunteers in the commonwealth. The commissioner shall review ways in which the commonwealth may act to provide legal counsel and defense to volunteers who may be eligible for the protections afforded in the Volunteer Protection Act of 1997 or the Free Clinics Federal Tort Claims Act Medical Malpractice Program. The commissioner shall report the results of the review by filing them with the joint committee on health care, together with a recommendation for legislation, if any, by December 31, 2005.

SECTION 58L. Notwithstanding any general or special law to the contrary, there shall be a demonstration program pertaining to health care coverage for fishermen administered by the Health Safety Net Office.

SECTION 58M. There is hereby established a MassHealth provider payment account, administered by

the secretary of the executive office of health and human services. Subject to the availability of federal financial participation, funds shall be expended from this account for supplemental Medicaid payments to qualifying providers.

SECTION 58N. The comptroller shall transfer $366,000,000 from the General Fund to the MassHealth provider payment account established to make supplemental Medicaid rate payments to qualifying providers.

SECTION 58O. Not later than July 1, 2006, the governing committee established in section 8 of chapter 178J of the General Laws shall submit to the commissioner of insurance a proposal for effectively terminating the operation of the plan established by said section 8 of said chapter 176J. The proposal shall be subject to the approval of the commissioner and shall be fully implemented not later than 12 months after such approval.

SECTION 58P. Not later than July 1, 2006, the governing committee established in subsection (b) of section 6 of chapter 176M of the General Laws shall submit to the commissioner of insurance a proposal for effectively terminating the operation of the plan established by subsection (a) of said section 6 of said chapter 176M. The proposal shall be subject to the approval of the commissioner and shall be fully implemented not later than 12 months after such approval.

SECTION 58Q. The joint committee on state administration and regulatory oversight, the joint committee on health care financing and the house and senate committees on ways and means, in this section called the committees, may review, individually or severally, regulations proposed or adopted pursuant to this act. The committees may hold public hearings concerning a proposed or existing regulation and may submit to the department comments concerning the merit and appropriateness of the regulations to be promulgated and an opinion whether the regulations are authorized by, and consistent with, this act. The department shall respond in writing within 10 days to the committees' written questions relevant to the committees' review of a proposed or existing regulation. The department shall provide to the committees, without charge, copies of all public records in its custody relating to the regulation or action in question within 10 days of a request by the committees. The committees may

issue a report with proposed changes to a proposed or existing regulation and shall transmit this report to the department. If the department does not adopt the proposed changes contained in the committees' report, the department shall notify the committees in writing of the reasons why it did not adopt the changes either at the time it adopts a proposed regulation or within 21 days of receiving the committees' report on an existing regulation.

SECTION 59. Section 8 shall be effective for tax years beginning on or after January 1, 2006.

SECTION 59A. Section 12DD of chapter 112, inserted by section 11A, shall apply to all expressions of regret or apology, whether made before, on or after the effective date of this act, except: (a) expressions of regret or apology on behalf of a person who is licensed by the board of registration in medicine who was examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding before the effective date of this act; (b) any civil action in which a judgment was entered in court before the effective date of this act; or (c) to any administrative proceeding in which a final order was entered before the effective date of this act.

SECTION 59B. Sections 12A, 13B½ and 13B¾ shall take effect on July 1, 2006.

SECTION 60. Section 34 shall apply to policies delivered, or issued for delivery, in the commonwealth on or after January 1, 2005. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with applicable insurance laws insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall apply to long-term care insurance.

SECTION 61. Section 44 shall expire on October 30, 2010.

SECTION 62. Sections 12 and 13B shall be effective on July 1, 2006.