

**UNCORRECTED PROOF**

**Thursday, July 22, 2010 (at 12:00 o'clock noon).**

Prayer was offered by the Reverend Robert F. Quinn, C.S.P., Chaplain of the House, as follows:

Gracious God, our Help in ages past and our Hope for years to come, we begin today's legislative session with a prayer in which we turn our attention to You and to spiritual thoughts and values. We believe that Your ways and teachings show us how to live a happy, productive and meaningful life. You are also our source of strength and hope as we struggle to cope with the many challenges which we face daily as elected representatives of the people in these changing times. With Your assistance, may our thoughts be clarified and our purpose strengthened as we struggle to address the items on today's calendar. Inspire us to work together in these uneasy times so that our communities will prosper, be safe, peaceful and beneficial for future generations.

Grant Your blessings to the Speaker, the members and employees of this House and their families. Amen.

At the request of the Chair (Mr. Donato), the members, guests and employees joined with him in reciting the pledge of allegiance to the flag.

*Appointment of the Minority Leader.*

The Minority Leader announced that he had appointed Dr. Vito R. S. Cardone, a member of the public from the town of Lynnfield, to the Biomedical Research Advisory Council established (under Section 9 of Chapter 111L of the General Laws, as enacted by Section 1 of Chapter 27 of the Acts of 2005) to report annually on the provisions of said law including an update on the current state of pre-implantation embryo research relating to human embryonic stem cell research in the Commonwealth.

*Petitions.*

Mr. Webster of Pembroke presented a petition (accompanied by bill, House, No. 4918) of Daniel K. Webster (by vote of the town) for legislation to authorize the town administrator of the town of Pembroke to approve all warrants for the expenditure of funds made by said town; and the same was referred to the committee on Municipalities and Regional Government. Sent to the Senate for concurrence.

Mr. Petrolati of Ludlow being in the Chair,—

Representatives Canavan of Brockton and Brady of Brockton presented a petition (subject to Joint Rule 12) of Christine E. Canavan, Thomas P. Kennedy and Michael Brady for legislation to establish a sick leave bank for Christopher Lemoing, an employee of the sheriff's department of Plymouth County; and the same was referred, under Rule 24, to the committee on Rules.

Mr. Binienda of Worcester, for the committee on Rules and the committees on Rules of the two branches, acting concurrently, then reported recommending that Joint Rule 12 be suspended. Under suspension of the rules, on motion of Mr. Pedone of Worcester, the report was considered forthwith. Joint Rule 12 was

Prayer.

Pledge of  
allegiance.

Biomedical  
Research  
Advisory  
Council.

Pembroke,—  
warrants.

Christopher  
Lemoing,—  
sick leave  
bank.

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suspended; and the petition (accompanied by bill) was referred to the committee on Public Service. Sent to the Senate for concurrence.

Mr. Alicea of Charlton (by request) presented a petition (subject to Joint Rule 12) of Peter Durant for legislation to further regulate the leasing of private property for the location of agencies and departments of the Commonwealth; and the same was referred, under Rule 24, to the committee on Rules.

Private property,—leasing.

*Papers from the Senate.*

The House Bill relative to property tax exemptions in the town of Ashland (House, No. 1904, changed) came from the Senate passed to be engrossed, in concurrence, with an amendment striking out section 1 and inserting in place thereof the following section:

Ashland,—property tax exemption.

“SECTION 1. Notwithstanding clause Forty-first C ½ of section 5 of chapter 59 of the General Laws or any other general or special law, or rule or regulation to the contrary, the town of Ashland may determine eligibility for the real estate tax exemption under said clause Forty-first C ½ of said section 5 of said chapter 59 based on the gross receipts of the taxpayer from all sources or, if the taxpayer is married, combined gross receipts.”

Under suspension of Rule 35, on motion of Mr. Sannicandro of Ashland, the amendment (reported by the committee on Bills in the Third Reading to be correctly drawn) was considered forthwith; and it was adopted, in concurrence.

The House Bill relative to certain exemption Massachusetts automobile insurance plans (House, No. 4476, amended) came from the Senate passed to be engrossed, in concurrence, with an amendment in section 2, in line 24, inserting after the word ”producers” the following “, 2 of whom shall be producers who are assigned risk producers who write private passenger automobile insurance exclusively through the Massachusetts automobile assigned risk plan pursuant to the provisions of the plan approved under this section.”

Auto insurance,—exemptions.

Under suspension of Rule 35, on motion of Mr. Mariano of Quincy, the amendment (reported by the committee on Bills in the Third Reading to be correctly drawn) was considered forthwith; and it was adopted, in concurrence.

Petitions severally were referred, in concurrence, under suspension of Joint Rule 7B, as follows:

Petition (accompanied by bill, Senate, No. 2526) of Michael O. Moore, Harriette L. Chandler and John J. Binienda (with the approval of the mayor and city council) for legislation relative to the enforcement of illegal dumping violations in the city of Worcester. To the committee on the Judiciary.

Worcester,—dumping violations.

Petition (accompanied by bill, Senate, No. 2527) of Michael O. Moore and Harriette L. Chandler (with the approval of the mayor and city council) for legislation to provide for the placement of certain abatement information on the property tax bill. To the committee on to the committee on Revenue.

Worcester,—tax bill information.

A petition of Scott P. Brown for legislation to designate a certain bridge in the town of Mansfield as the Sergeant Douglas Weddleton Memorial Bridge, came from the Senate referred, under suspension of Joint Rule 12, to the committee on Transportation.

Sgt. Douglas Weddleton,—bridge.

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The House then concurred with the Senate in the suspension of said rule; and the petition (accompanied by bill, Senate, No. 2528) was referred, in concurrence, to the committee on Transportation.

*Reports of Committees.*

By Mr. Binienda of Worcester, for the committee on Rules and the committees on Rules of the two branches, acting concurrently, that Joint Rule 12 be suspended on the following petitions:

Petition (accompanied by bill) of Brian P. Wallace that the Department of Revenue be authorized to establish a sick leave bank for Donald F. Johnson, an employee of said department; and

Donald Johnson,—  
sick leave.

Petition (accompanied by bill) of William M. Straus relative to establishing a sick leave bank for Matthew Normandeau, an employee of the Bristol County Sheriff's Office.

Matthew Normandeau,—  
sick leave.

Severally to the committee on Public Service.

Under suspension of the rules, on motion of Mr. Pedone of Worcester, the reports were considered forthwith. Joint Rule 12 then was suspended, in each instance. Severally sent to the Senate for concurrence.

By Mr. Kafka of Stoughton, for the committee on Steering, Policy and Scheduling, that the House Bill relating to improving quality in early education and care by family child care providers (House, No. 494, changed) be scheduled for consideration by the House, with the amendment previously recommended by the committee on Ways and Means,— that the bill be amended by substitution of a bill with the same title (House, No. 4917),— pending.

Family child  
care providers.

Under suspension of Rule 7A, on motion of Mr. Scaccia of Boston, the bill was read a second time forthwith.

The amendment recommended by the committee on Ways and Means then was adopted; and the substituted bill was ordered to a third reading.

Subsequently, under suspension of the rules, on further motion of the same member, the bill (having been reported by the committee on Bills in the Third Reading to be correctly drawn) was read a third time; and it was passed to be engrossed, its title having been changed by said committee to read: "An Act relative to early education and care by family child care providers.". Sent to the Senate for concurrence.

By Mr. Naughton of Clinton, for the committee on Veterans and Federal Affairs, on a petition, a Bill further amending the Welcome Home Bill (House, No. 3405). Read; and referred, under Rule 33, to the committee on Ways and Means.

Servicemen,—  
insurance.

By Mr. Donato of Medford, for the committee on Municipalities and Regional Government, on a petition, a Bill further regulating tax titles in the town of East Bridgewater (House, No. 4678) [Local Approval Received]. Read; and referred, under Rule 7A, to the committee on Steering, Policy and Scheduling.

East  
Bridgewater,—  
tax titles.

*Engrossed Bills.*

Engrossed bills

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Relative to the interest rate to be charged on certain betterment assessments in the town of Wareham (see Senate, No. 2140);

Bills  
enacted.

Relative to interest rates to be charged upon apportioned betterment assessments in the town of Wareham (see Senate, No. 2141); and

To regulate the use of off highway and recreation vehicles (see Senate, No. 2257, amended).

(Which severally originated in the Senate); and

Relative to the preparation of certain ballots in the city of Boston (House, No. 4880, amended) (which originated in the House);

Severally having been certified by the Clerk to be rightly and truly prepared for final passage, were passed to be enacted; and they were signed by the acting Speaker and sent to the Senate.

The engrossed Bill relative to school nutrition (see House, No. 4459) (which originated in the House), having been certified by the Clerk to be rightly and truly prepared for final passage, was put upon its final passage.

Bill  
enacted.

After debate, the bill was passed to be enacted; and it was signed by the acting Speaker and Senate to the Senate.

*Engrossed Bill – Land Taking.*

The engrossed Bill authorizing the town of Manchester-by-the-Sea to grant an easement over certain land acquired for water supply purposes (see House, No. 4304, amended) (which originated in the House), having been certified by the Clerk to be rightly and truly prepared for final passage, was put upon its final passage.

Manchester-by-  
the-Sea.

On the question on passing the bill to be enacted, the sense of the House was taken by yeas and nays (this being a bill providing for the taking of land or other easements used for conservation purposes, etc., as defined by Article XCVII of the Amendments to the Constitution); and on the roll call 150 members voted in the affirmative and 0 in the negative.

Bill enacted  
(land taking),—  
yea and nay  
No. 453.

**[See Yea and Nay No. 453 in Supplement.]**

Therefore the bill was passed to be enacted; and it was signed by the acting Speaker and sent to the Senate.

*Orders of the Day.*

The report of the committee of conference on the disagreeing votes of the two branches with reference to the House amendment of the Senate Bill relative to kayaks (Senate, No. 974) recommending passage of a Bill relative to kayak safety (Senate, No. 2518) was accepted, in concurrence.

Kayak  
safety.

House bills

Providing equity for school principals (House, No. 371, changed) (its title having been changed by the committee on Bills in the Third Reading);

Third  
reading  
bills.

Relative to health insurance and other benefits in the town of Phillipston (House, No. 4196) (its title having been changed by the committee on Bills in the Third Reading);

Establishing the Caleb Chase gift account for the town of Harwich (House, No. 4587) (its title having been changed by the committee on Bills in the Third

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Reading);

Authorizing the town of Westford to lease a certain parcel of land for camp purposes (House, No. 4662) (its title having been changed by the committee on Bills in the Third Reading);

Relative to disabled firefighters (House, No. 4463) (its title having been changed by the committee on Bills in the Third Reading); and

Authorizing the city of Gardner to convey certain land under the control of the Gardner Conservation Commission (House, No. 4679) (its title having been changed by the committee on Bills in the Third Reading);

Severally reported by said committee to be correctly drawn, were read a third time; and passed to be engrossed. Severally sent to the Senate for concurrence.

The House Bill relative to special license plates for certain military personnel (House, No. 4588) was read a third time.

Third reading  
bill amended.

The committee on Bills in Third Reading reported recommending that the bill be amended by substitution of a bill with the same title (House, No. 4923); and the report was accepted.

The amendment was adopted; and the substituted bill was passed to be engrossed. Sent to the Senate for concurrence.

The House Bill relative to inhalant abuse (House, No. 4254) was read a second time; and it was ordered to a third reading.

Second  
reading  
bill.

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The House Bill eliminating the word “retardation” from the General Laws (House, No. 176), reported by the committee on Bills in the Third Reading to be correctly drawn, was read a third time.

“Retardation”,—  
delete from  
General Laws.

The committee on Bills in the Third Reading reported asking to be discharged from further consideration of the bill; and the report was accepted.

Pending the question on passing the bill to be engrossed, Mr. Pedone of Worcester moved to amend it by substitution of a bill with the same title (House, No. 4922), which was read.

The amendment was adopted; and the substituted bill was passed to be engrossed. Sent to the Senate for concurrence.

The House Bill authorizing the town of Winthrop and the Winthrop Housing Authority to grant certain easements for underground electric and intelligence transmission and distribution cables (House, No. 4766), reported by the committee on Bills in the Third Reading to be correctly drawn, was read a third time.

Winthrop,—  
easements.

Pending the question on passing the bill to be engrossed, Mr. Pedone of Worcester moved to amend it by striking out sections 4 and 5 and inserting in place thereof the following three sections:

“SECTION 4. The land described in section 1 is subject to a restriction under the ‘Declaration of Covenant’ entered into between the town of Winthrop and the United States Department of Education dated May 21, 1999 and recorded in the Suffolk county registry of deeds in book 23931, page 172 and the grant of the easement by the town of Winthrop pursuant to said section 1 is not authorized under said Declaration of Covenant and shall be subject to advance written approval by

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the United States Department of Education.

SECTION 5. The town of Winthrop and the Winthrop Housing Authority shall execute, acknowledge, and deliver to the United States Department of Education, or its successor in function, and the Massachusetts Electric Company, its successors and assigns, such further deeds or instruments or other documents as may be necessary for the purposes set forth in this act.

SECTION 6. This act shall take effect upon its passage.”.

The amendment was adopted; and the bill (House, No. 4766, amended) was passed to be engrossed. Sent to the Senate for concurrence.

The Senate Bill establishing a sick leave bank for Sharon Baert, an employee of the Department of Developmental Services (Senate, No. 2466, amended), reported by the committee on Bills in the Third Reading to be correctly drawn, was read a third time, under suspension of the rules, on motion of Ms. Ferrante of Gloucester; and it was passed to be engrossed, in concurrence.

Sharon  
Baert,—  
sick leave  
bank.

The House Bill establishing a sick leave bank for Colleen Robichaud, an employee of the Registry of Motor Vehicles (House, No. 4777), reported by the committee on Bills in the Third Reading to be correctly drawn, was read a third time, under suspension of the rules, on motion of Mr. Rodrigues of Westport; and it was passed to be engrossed. Sent to the Senate for concurrence.

Colleen  
Robichaud,—  
sick leave.

*Reports of Committees.*

By Kafka of Stoughton, for the committee on Steering, Policy and Scheduling, that the Senate Bill to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses (Senate No. 2447) be scheduled for consideration by the House, with the amendment previously recommended by the committee on Ways and Means,—that the bill be amended by striking out all after the enacting clause and inserting in place thereof the text contained in House document numbered 4915,— pending.

Health  
insurance.

Under suspension of Rule 7A, on motion of Mr. Mariano of Quincy, the bill was read a second time forthwith.

The amendment recommended by the committee on Ways and Means then was adopted; and the bill (Senate, No. 2447, amended) was ordered to a third reading.

Subsequently, under suspension of the rules, on further motion of the same member, the bill (having been reported by the committee on Bills in the Third Reading to be correctly drawn) was read a third time.

After remarks on the question on passing the bill, as amended, to be engrossed, in concurrence, Mr. Tobin of Quincy moved to amend it by adding the following two sections:—

“SECTION 67. Section 9(b) of chapter 94C of the General Laws is hereby amended in the third paragraph by inserting at the end thereof the following:—

This section shall not be construed to prohibit a physician or an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession’s designated scope of practice.

‘Therapeutic contact lenses’ means contact lenses which contain one or more medications and which deliver such medication to the eye.

SECTION 67A. Section 66b of Chapter 112 of the General Laws is hereby

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amended after the third paragraph by inserting the following:—

This section shall not be construed to prohibit an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession's designated scope of practice.

'Therapeutic contact lenses' means contact lenses which contain one or more medications and which deliver such medication to the eye."

The amendment was adopted.

Mr. Spellane of Worcester then moved to amend the bill by adding the following section:

"SECTION 68. Section 2 of Chapter 32A of the general Laws, as appearing in the 2006 Official Edition, is hereby amended by adding at the end thereof the following new definition:—

'Wellness program', is a program designed to measure and improve individual health by identifying risk factors, principally through diagnostic testing, and establishing plans to meet specific health goals which include appropriate preventive measures. Risk factors may include but not be limited to demographics, family history, behaviors and measured biometrics.

Said Chapter 32A is hereby further amended by adding at the end thereof the following new section:-

The commission shall negotiate with and purchase, on such terms as it deems to be in the best interest of the commonwealth and its employees, from one or more entities that can manage a wellness program covering persons in the service of the commonwealth and their dependents, and shall execute all agreements or contracts pertaining to said program. Said commission may negotiate a contract for such term not exceeding five years as it may, in its discretion, deem to be the most advantageous to the commonwealth; provided, however that said program must be able to evaluate individual and aggregate data, give employees access to their individual information confidentially, and allow the commission to receive collective reports summarizing baseline and ongoing data regarding the behavior and well being of enrollees. The commission may reduce premiums or co-payments or offer other incentives to encourage enrollees to comply with the wellness program goals.

A report of the collective results, including but not limited to the level of participation among employees, incentives provided for participation, the number and type of screenings and diagnostic tests conducted, the instance of undiagnosed risks defined as out of range diagnostic tests, and number of employees seeking and receiving preventative treatment shall be submitted annually to the governor, the secretary of the executive office of health and human services, the secretary for administration and finance, the chairmen of the joint committees on health care financing, house and senate committees on ways and means, the speaker of the house, and the senate president. The commission shall use this information in the negotiating and purchasing, on such terms as it deems in the best interest of the commonwealth and its employees, from one or more insurance companies, savings banks or non-profit hospital or medical service corporations, a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits covering persons in the service of the commonwealth and their dependents. The commission shall also report annually to the governor, secretary for administration and finance, the chairmen of the joint committees on health care financing, house and senate

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committees on ways and means, the speaker of the house, and the senate president on the savings that have been achieved in procuring such insurance policies since implementing the wellness program.”.

The amendment was adopted.

Mr. Rodrigues of Westport then moved to amend the bill adding the following section:

“SECTION 69. The General Laws are hereby amended by inserting after chapter 175K the following chapter:-

Chapter 175L

Regulation of Pharmacy Audits

Section 1. Definitions.

For purposes of this chapter the following terms shall have the following meanings:

‘Pharmacy Benefits Manager’ any person or entity that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors such as self-insured employers, insurance companies, and labor unions. A health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this chapter unless specifically exempted. The provisions of this chapter shall not apply to a public health care payer as defined in section 1 of chapter 118G.

‘Commissioner’, the commissioner of insurance or his designee.

Section 2. Certification of Pharmacy Benefits Managers

(a) Except as provided in subsection (d) of this section, no person shall act as a pharmacy benefits manager without first obtaining a certificate of registration from the commissioner. (b) Any person seeking a certificate of registration shall apply to the commissioner, in writing, on a form provided by the commissioner. The application form shall state (1) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager, and (2) the name and address of the applicant's agent for service of process in the Commonwealth. (c) Each application for a certificate of registration shall be accompanied by a nonrefundable fee set by the Commissioner of no less than five hundred dollars. (d) A health benefit plan that does not contract with a pharmacy benefit manager shall not be required to obtain a certificate of registration. Such health benefit plan shall notify the commissioner annually, in writing that it is affiliated with or operating a business as a pharmacy benefits manager. (e) Any person acting as a pharmacy benefits manager on January 1, 2011, and required to obtain a certificate of registration under subsection (a) of this section, shall obtain a certificate of registration from the commissioner not later than April 1, 2011.

Section 3. Audit Scope and Procedures.

(a) Notwithstanding any general or special law to the contrary, an audit of the records of a pharmacy conducted by a pharmacy benefit manager shall follow these procedures:

(1) The contract between a pharmacy and a pharmacy benefit manager shall identify and describe in detail the audit procedures;

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(2) The auditor shall give the pharmacy written notice at least one week prior to conducting the initial on-site audit for each audit cycle;

(3) The auditor shall not interfere with the delivery of pharmacist services to a patient and shall make reasonable effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

(4) Any audit which involves clinical or professional judgment shall be conducted by or in consultation with a licensed pharmacist from any state. ;

(5) A pharmacy may use the records of a hospital, physician, or other authorized prescriber to validate the record with respect to orders or refills of prescription drugs or devices.

(6) A finding of an overpayment or underpayment shall be based on the actual overpayment or underpayment. A projection for overpayment or underpayment may be used to determine recoupment as part of a settlement as agreed to by the pharmacy. ;

(10) Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity;

(12) An audit may not be initiated or scheduled during the first five calendar days of any month due to the high volume of prescriptions filled in the pharmacy during that time unless otherwise consented to by the pharmacy;

(b) The auditor shall provide the pharmacy with a written report of the audit.

(10) The audit report shall be signed and shall include the signature of any pharmacist participating in the audit.

(11) A pharmacy benefit manager shall not withhold payment to a pharmacy for reimbursement claims as a means to recoup money owed to the pharmacy benefit manager by said pharmacy as a result of an audit unless an identified discrepancy for a preliminary audit exceeds \$25,000.

(12) The auditor shall provide a copy of the final audit report, after completion of any review process, to the plan sponsor.

**Section 4. Appeal Process.**

(a) Each auditor shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(b) The National Council for Prescription Drug Programs (“NCPDP”) or any other recognized national industry standard shall be used to evaluate claims submission and product size disputes.

(c) If, following the appeal, the auditor finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or said portion without the necessity of any further action.

**Section 5.** The provisions of this chapter shall not apply to any audit or investigation that involves potential fraud, willful misrepresentation, or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision that authorizes investigations relating to insurance fraud.

**Section 6.** The commissioner may promulgate regulations to enforce the provisions of this chapter including, but not limited to, oversight of the following audit practices:

(a) The number of days by which a preliminary audit report shall be delivered to the pharmacy after conclusion of the audit.

(b) The number of days by which a pharmacy shall be allowed to address any discrepancy found during the preliminary audit;

(c) The number of days by which a final audit report shall be delivered to the pharmacy after receipt of the preliminary audit report or final appeal, as provided

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for in section 4, whichever is later;

(d) The means by which a pharmacy benefit manager may request information from a pharmacy.

Section 7. The audit criteria set forth in this chapter shall apply only to audits of claims for services provided and claims submitted for payment after April 1, 2011.”

After remarks the amendment was rejected.

Mr. Kujawski of Webster then moved to amend the bill in section 58 (as printed), in line 945, by striking out the following “27 to 29, inclusive” and inserting in place thereof the figures “, 27, 28”; and in section 61 (as printed), in line 949, by inserting after the figures “26” the figures “, 29”. The amendments were adopted.

Ms. Grant of Beverly then moved to amend the bill section 2, in line 38, by inserting after the word “commonwealth.” the following sentence “As of January 1, 2011, the membership of the Health Care Quality and Cost Council must be comprised of members where no less than one-third shall be a mixture of nurse practitioners and physicians who are or have been active clinical providers of health care to patients.”

After remarks the amendment was rejected.

Mr. Scibak of South Hadley then moved to amend the bill by adding the following two sections:

“SECTION 69. The first sentence of subsection (b) of said section 2 of said chapter 111M of the General Laws is hereby amended by striking out clauses (ii) and (iii) and inserting in place thereof the following clauses:- (ii) claims an exemption under section 3, (iii) had a certificate issued under section 3 of chapter 176Q, or (iv) had adjusted gross income as shown on the individual’s state tax return such that the amount required to purchase the lowest cost insurance on the market for which an individual would be eligible for creditable coverage, taking into consideration the out of pocket costs, as shown in the schedule created pursuant to subsection (p) of section 3 of chapter 176Q, exceeds the amount which an individual could be expected to contribute towards the purchase of insurance in the report published pursuant to subsection (q) of section 3 of chapter 176Q.

SECTION 70. Said section 2 of chapter 111M of the General Laws, as so appearing, is hereby further amended by inserting after subsection (c) the following subsections:—

(d) The affordability schedule set by the board of the connector pursuant to subsection (a) shall be subject to the following requirements:

(1) in determining whether creditable coverage is affordable, the board of the connector shall consider expected enrollee expenditures as the 90th percentile of out of pocket costs plus premiums for those enrolled in creditable coverage;

(2) For the purposes of this section, ‘out-of-pocket costs’ shall mean the amount paid by an enrollee to satisfy the applicable annual deductible, co-payments and co-insurance, not including monthly premiums.”

The amendment was rejected.

Mr. Jones of North Reading and other members of the House then moved to amend the bill by inserting after section 57 (as published), the following section:

“SECTION 60A. There shall be a special commission to be referred to as the MassHealth Cost Control Commission to investigate the use of co-payments for MassHealth members with the goal of encouraging the most cost effective use of health care resources. The investigation shall include, but not be limited to, the study of savings that would result from charging a small co-payment for the use of

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emergency care in non-emergency situations, in order to discourage the inappropriate use of health care resources. The inappropriate use of health care resources may be defined as any instance in which an individual seeks care in an emergency room department but whose medical needs do not warrant in-patient medical care.

The commission shall investigate possible cost-savings for the MassHealth program and any positive and negative deterrent effects a co-payment will have on MassHealth members, in encouraging members to use primary care rather than emergency care in non-emergency situations.

The MassHealth Cost Control Commission shall consist of 9 members: 1 member who shall be a representative of a major hospital within the commonwealth, appointed by the Governor; 1 member who shall be an advocate for MassHealth members, appointed by the director of Medicaid; 1 member who shall be an expert in national health care policy, appointed by the Governor; 1 member who shall be a representative of MassHealth, appointed by the director of Medicaid; 1 member who shall be a taxpayer's advocate, appointed by the Governor; 1 member of the senate, appointed by the senate president; 1 member, appointed by the senate minority leader; 1 member of the house of representatives, appointed by the speaker of the house; and 1 member, appointed by the house minority leader.

The Commission shall submit its report and findings, along with any draft of legislation, to the house and senate committees on ways and means, the joint committee on health care financing, and the clerks of the house of representatives and the senate within 90 days of the passage of this act.”

The amendment was adopted.

Mr. Murphy of Burlington being in the Chair,—

Mr. Jones of North Reading and other members of the House then moved to amend the bill in section 55 (as changed by the committee on Bills in the Third Reading), in line 885, by inserting after the word “president” the following “; 1 person appointed by the minority leader of the house of representatives; 1 person appointed by the minority leader of the senate”.

The amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill by inserting after section 13 (as printed) the following section:

“SECTION 16A. Section 188 of chapter 149 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting in line 14 after the word ‘individual’, the following:- ,who is a resident of the Commonwealth of Massachusetts.”

The amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill by striking out section 19; and the amendment was rejected.

Mr. Basile of Boston then moved to amend the bill in section 16 (as printed), in line 228, by inserting after the word “to” the words “any discount or free product vouchers that a retail pharmacy provides to a consumer in connection with a pharmacy service or prescription transfer offer, or to”. The amendment was adopted.

Mr. Cabral of New Bedford then moved to amend the bill in section 12 (as printed), in lines 181 and 197, by inserting after the word “group”, in each instance, the words “; provider group”; and in section 45, in line 724, by inserting after the word “groups,” the following: “provider groups or”, and in lines 732 and 733, by inserting after the words “groups”, in each instance, the words “and provider

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groups”. The amendments were adopted.

Mr. Cabral of New Bedford then moved to amend the bill in section 49, in line 795, by inserting after the words “Plans, Inc.” (as changed by the committee on Bills in the Third Reading) the following: “, a representative of an association of health care providers licensed under chapter 112 who is not a medical doctor”; and in section 55, in line 888 by inserting after the word “hospitals” the following “; 1 person designated by the Massachusetts Public Health Association”. The amendments were adopted.

Mr. Webster of Hanson and other members of the House then moved to amend the bill by inserting after section 39 the following section:

“SECTION 39A. Section 3 of Chapter 176Q of the General Laws, as so appearing, is hereby amended by inserting after subsection (t) the following paragraph:-

Nothing in this section shall be construed as to authorize the Connector to actively solicit potential participants in their health insurance plans if such participants already have coverage for such plans from private companies.”.

The amendment was adopted.

Mr. Peterson of Grafton and other members of the House then moved to amend the bill by inserting after section 16A (inserted by amendment) the following two sections:

“SECTION 16B. Section 188 of chapter 149 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out, in line 19, the word ‘equivalent’.

SECTION 16C. Subsection (b) of section 188 of chapter 149 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following sentence:- Any employee who has health care coverage via a qualifying health insurance plan from a spouse, parent, veteran’s plan, Medicare, Medicaid or a plan or plans due to the disability or retirement shall not be included in the calculation for the fair share employer contribution.”.

The amendment was adopted.

Messrs. Donato of Medford and Golden of Lowell then moved to amend the bill in section 36, in line 624, by inserting after the word “approval;” the following: “ or (v) allows the carrier to uniformly categorize providers of a type of licensure under chapter 112 of the General Laws in the same tier of a tiered network plan”. The amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill by striking out section 57 (as printed) and inserting in place thereof the following section:

“SECTION 60. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until December 31, 2014. This moratorium shall not apply to any proposed mandated benefit that has been enacted by the general court prior to December 31, 2011; except when it is shown that the mandate will reduce the cost, as determined by the division of health care finance and policy.”.

The amendment was adopted.

Ms. Peisch of Wellesley then moved to amend the bill by adding the following section:

“SECTION 69. Individuals shall have the option to opt out of the prescription drug coverage requirement included as part of the minimum creditable coverage for health insurance through the commonwealth health insurance connector if the

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individual can demonstrate his or her financial ability to pay for prescriptions drugs by establishing an escrow account with a minimum value of \$5,000.”.

The amendment was adopted.

Mrs. Canavan of Brockton and other members of the House then moved to amend the bill in section 28, in line 417, and also in section 43, in line 681, by inserting after the word “management”, in each instance, the words “, care management”; and in section 44, in line 707, and also in section 45, in line 730, by inserting after the words “pay-for-performance”, in each instance, the words “, care management payments”. The amendments were adopted.

Mr. Costello of Newburyport then moved to amend the bill by inserting after section 46 the following section:

“SECTION 46A. Notwithstanding the provisions of any general or special law to the contrary, the Division of Medical Assistance shall promulgate regulations on or before January 1, 2011 that are designed to conform the ordering of treatment related urine drug screens with both Chapter 160 of the Acts of 2006 governing independent clinical laboratory services and the Department of Public Health regulations at 105 CMR 164 et. seq. governing the provisions of substance abuse treatment services, by revising its definition of ‘authorized prescriber’ at 130 CMR 401.402 to separately include, for the purpose of ordering treatment related random urine drug screens, substance abuse treatment programs that are licensed by the Department of Public Health's Bureau of Substance Abuse Services.”.

The amendment was adopted.

Ms. Wolf of Cambridge then moved to amend the bill by adding the following section:

“SECTION 70. Notwithstanding any general or special law to the contrary, the secretary of the executive office of health and human services, in coordination with the commissioner of the division of health care finance and policy, is authorized to pursue federal Medicaid global payment and accountable care organization opportunities, including the Medicaid Global Payment System Demonstration under Section 2705 of the Patient Protection and Affordable Care Act and other similar opportunities, with 1 or more hospitals or hospital systems in the commonwealth. The secretary shall report to the house and senate committees on ways and means and the joint committee on health care financing 30 days prior to implementing said demonstration project.”.

The amendment was adopted.

Mr. Falzone of Saugus and other members of the House then moved to amend the bill by adding the following section:

“SECTION 71. Notwithstanding any other general or special law to the contrary, the secretary of administration and finance, in consultation with the secretary of the executive office of elder affairs, the commissioner of the divisional of medical assistance, the commissioner of the department of public health and the executive director of the group insurance commission, shall, within 60 days of the passage of this act, develop a program to aggregate the purchase of prescription drugs for individuals and small businesses eligible and covered by small group health insurance, as defined in Chapter 176J of the general laws, hereinafter, the "Coverage Group". In order to ensure the timely performance of his obligations under this act, the secretary of administration and finance may enter into an agreement with a not-for-profit entity for the purpose of developing and managing said program.

As part of said program, the secretary of administration and finance or his

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designee, shall prepare a request for proposals for the purpose of selecting one or more entities to provide prescription drug benefit management services to members of the Coverage Group. The selection process shall include criteria designed to select that entity best able to provide a prescription drug benefit program for the Coverage Group in a way that maximizes savings for the commonwealth and participants without reducing the quality of prescription drug benefits, if any, now being provided to the Coverage Group.

Prior to finally accepting a proposal to provide said prescription drug benefit management services, the secretary, in conjunction with the house and senate chairs of the joint committee on health care, the chair of the senate committee on ways and means and the chair of the house committee on ways and means, shall conduct a public hearing to consider testimony on the public benefits of all proposals submitted. The secretary and said chairs shall take oral and written testimony at the hearing. After the hearing, the secretary shall solicit from said chairs their input regarding the selection of one of the proposals. The secretary shall select a proposal, if any, only after making a determination in writing that it maximizes savings to the commonwealth, or provides other substantial public benefits, in a way that does not reduce the quality of existing prescription drug services for the Coverage Group. At least 30 days before the secretary's selection becomes final, he shall submit a report containing his selection, along with the basis therefor, to the house and senate chairs of the joint committee on health care, the chair of the senate committee on ways and means and the chair of the house committee on ways and means.

The accepted proposal shall not terminate any contract currently in existence with any agency or program affected hereunder which cannot be favorably renegotiated.”.

The amendment was adopted.

Mr. Kocot of Northampton then moved to amend the bill in section 34, in lines 545 to 548, inclusive, 545, by striking out the paragraph in those line and inserting in place thereof the following paragraph:

“(1) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, greater than or equal to 10 per cent above the carrier’s statewide adjusted average in the previous year beginning October 1 through September 30 shall not increase rates to be paid under that contract beyond the prior year’s existing rate; provided, however, that this provision shall not apply to a contract between a carrier and a health care provider where the health care provider is located in a metropolitan statistical area (referred to herein as a MSA) in which the total health care cost per person per year for all health care providers’ services provided to persons who are residents of such MSA and who are enrolled in all of such carrier’s health benefit plans is no greater than 10 per cent above the average of the total health care cost per person per year per MSA for all health care providers’ services provided to persons who are residents of the commonwealth and who are enrolled in all of such carrier’s health benefit plans.”; and in said section, in lines 566 to 570, inclusive, by striking out the paragraph in those lines and inserting in place thereof the following paragraph:

“(b) Notwithstanding subsection (a) a carrier shall not enter or renew a contract or agreement on or after January 1, 2011 with a health care provider, including a hospital, physician group practice, or imaging service, under which the carrier agrees to pay the health care provider a rate that is greater than 15 per cent above or greater than 15 per cent below the carrier’s statewide adjusted average rate, as defined by the division of health care finance and policy; provided, however, that,

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for purposes of this paragraph and the following paragraph, a carrier may pay a provider a rate that is greater than 15 per cent above the carrier's statewide adjusted average rate where the health care provider is located in a MSA in which the total health care cost per person per year for all health care providers' services provided to persons who are residents of such MSA and who are enrolled in all of such carrier's health benefit plans is no greater than 15 per cent above the average of the total health care cost per person per year per MSA for all health care providers' services provided to persons who are residents of the commonwealth and who are enrolled in all of such carrier's health benefit plans.”.

The amendments were rejected.

Mr. Pignatelli of Lenox and other members of the House then moved to amend the bill in section 34, in lines 543 and 567, by inserting after the word “physician”, in each instance, the words “, or provider”. The amendments were adopted.

Mr. Koutoujian of Waltham then moved to amend the bill by adding the following four sections:

“SECTION 72. Chapter 175 of the General Laws is hereby amended by inserting after section 47U, inserted by section 8 of chapter 141 of the acts of 2000, the following section:—

Section 47V. No individual or group accident and health insurance policies and health service contracts can refuse to reimburse a physician at the full rate for necessary medical or surgical services provided by a physician assistant practicing under the supervision of a physician if the policy or contract would have paid for the same services when provided by a physician. Individual or group accident and health insurance policies and health service contracts cannot impose a practice or supervision restriction which is inconsistent or more restrictive than state law. Provided, however, that the following conditions are met:(1) the service rendered is within the scope of practice of physician assistants pursuant to section 9E of said chapter 112; (2) such service is provided in compliance with all other requirements of law, including a formal supervisory arrangement with a physician as provided for by said section 9E (3) the policy or contract provides benefits for such service if rendered by a registered physician in the commonwealth.

SECTION 73. Chapter 176A of the General Laws is hereby amended by inserting after section 8Z, the following section:—

Section 8V. No contract or subscription certificate between an insured and the corporation can refuse to reimburse a physician at the full rate for necessary medical or surgical services provided by a physician assistant, certified by the board of registration of physician assistants pursuant to the provisions of section 9F of chapter 112, practicing under the supervision of a physician if the contract or subscription certificate would have paid for the same services when provided by a physician. A contract or subscription certificate between an insured and the corporation cannot impose a practice or supervision restriction which is inconsistent or more restrictive than state law; provided, however, that the following conditions are met: (1) the service rendered is within the scope of practice of physician assistants pursuant to section 9E of said chapter 112; (2) such service is provided in compliance with all other requirements of law, including a formal supervisory arrangement with a physician as provided for by said section 9E; and (3) the contract or subscription certificate provided benefits for such service if rendered by a registered physician in the commonwealth.

SECTION 74. Chapter 176B of the General Laws is hereby amended by inserting after section 4U, inserted by section 4R the following section:—

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Section 4V. No contract or subscription certificate between an insured and the corporation can refuse to reimburse a physician at the full rate for necessary medical or surgical services provided by a physician assistant, certified by the board of registration of physician assistants pursuant to the provisions of section 9F of chapter 112, practicing under the supervision of a physician if the contract or subscription certificate would have paid for the same services when provided by a physician. A contract or subscription certificate between an insured and the corporation cannot impose a practice or supervision restriction which is inconsistent or more restrictive than state law; provided, however, that the following conditions are met: (1) the service rendered is within the scope of practice of physician assistants pursuant to section 9E of said chapter 112; (2) such service is provided in compliance with all other requirements of law, including a formal supervisory arrangement with a physician as provided for by said section 9E; and (3) the contract or subscription certificate provides benefits for such service if rendered by a registered physician in the commonwealth. No such contract or subscription certificate shall deny payment for such services solely on the basis that the service was provided by a physician assistant.

SECTION 75. The first paragraph of section 4 of chapter 176G of the General Laws is hereby amended by adding the following sentence:- Such health maintenance contract shall also provide coverage for the services rendered by a certified registered physician assistant, as set forth in section 47V of chapter 175, subject to the provisions of said section.”.

The amendment was adopted.

Mr. Kaufman of Lexington and other members of the House then moved to amend the bill by striking out section 40; and the amendment was adopted.

Mr. D’Amico of Seekonk then moved, there being no objection, to amend the bill by striking out section 34 (as previously amended) and inserting in place thereof the following two sections:

“SECTION 34. Chapter 176O is hereby amended by inserting after Section 5B the following section:—

Section 5C.

(a) No carrier shall enter or renew a contract or agreement on or after January 1, 2012 with any health care provider under which the carrier agrees to pay the health care provider at a rate that is 10% above or 10% below the carrier’s 2013 statewide relative price. The carrier’s annual average relative price shall be calculated using the standard method determined by the commissioner using the provider categories and uniform methodology for price relativities established by the division of health care finance and policy pursuant to section 6 of chapter 118G and shall be certified by an independent actuary selected by the carrier from a panel established by the division. Each carrier’s 2013 relative price shall be based on the carrier’s 2010 relative price adjusted annually by the percentage increase in the consumer price index for all urban consumers, as reported by the United States Bureau of Labor Statistics. For each subsequent year, the carrier’s relative price shall not increase at a rate greater than the annual percentage increase in the employment cost index for the private industry health care and social assistance industry group, as reported by the United States Bureau of Labor Statistics.

(b) Notwithstanding subsection (a), the commissioner of insurance may by regulation establish rate factors based on actuarially and statistically sound analysis of the differences in the cost of providing health care services for different rate factor categories of health care provider by specialty, academic status or geographic

location. A carrier may enter or renew a contract on or after January 1, 2013 under which the carrier agrees to pay the health care provider a rate that applies an applicable rate factor established under this section; provided, however, that the resulting rate may not be more than 15% above or 15% below the carrier's statewide relative price, as determined in paragraph (a), for all health care providers regardless of whether the rate factor applies to them or not. If a carrier chooses to apply a rate factor established by the commissioner, the carrier shall apply that rate factor consistently to every health care provider within that rate factor category, as determined by the commissioner. A carrier may not apply a rate factor established pursuant to this section to any health care provider that has not entered, renewed or renegotiated its contract to provide services with the carrier between the effective date of this act and January 1, 2013.

(c) Notwithstanding subsection (a), a carrier may enter a contract with a health care provider, under which the carrier agrees to pay the health care provider a rate or global budget rate calculated to result in health status adjusted total medical expenses for the primary care provider or group that is no more than 5% above the health status adjusted total medical expenses of the health care providers in the carrier's statewide network. The carrier's annual health status adjusted total medical expenses shall be calculated using the total medical expenses determined using the uniform methodology established by the division of health care finance and policy pursuant to section 6 of chapter 118G and shall be certified by an independent actuary selected by the carrier from a panel established by the division.

(d) Any savings realized by the carrier from any reduction or mitigation in the growth of provider prices shall be incorporated in the premiums charged to health plan members.

SECTION 34A. The division of insurance, in consultation with the division of health care finance and policy, shall conduct a study of the impact of Section 34 (section 5C of chapter 176O). The study shall include, but not be limited to, an examination of the impact on carrier provider networks, network adequacy, rates paid to non-participating providers, cost shifting across market segments, and the overall impact on carrier member premiums. The division may conduct a public hearing and receive input from interested parties. The division shall file a report with the clerks of the senate and house of representatives not later than January 1, 2014 on its findings and may make recommendations for legislation.”

After remarks the amendment was rejected.

Messrs. Conroy of Wayland and Mariano of Quincy then moved to amend the bill by striking out section 29 and inserting in place thereof the following section:

“SECTION 29. Said chapter 176J is hereby amended by adding the following section:—

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses at least one plan with either a reduced or selective network of providers. The base premium for the reduced or selective network, or any tiered network plan shall be at least 15 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers.

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(b) A tiered network plan shall only include variations on member cost-sharing between provider tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate access to covered services at lower patient cost sharing levels.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall tiered network plan.

(d) The commissioner shall determine network adequacy for a select network plan based on the availability of sufficient network providers in the carrier's select network of providers.

(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section. The report shall include the number of members enrolled by plan type, de-identified aggregate demographic, and geographic information on all members and the average direct premium claims incurred for selective and tiered network plans compared to non-selective and non-tiered plans.”; and by adding the following three sections:

“SECTION 76. Section 47H of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:—

For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION 77. Section 8K of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:-

For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION 78. Section 4J of chapter 176B of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:—

For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this

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section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.”.

The amendments were adopted.

Messrs. Conroy and Mariano then moved, there being no objection, to amend the bill by striking out section 34 and inserting in place thereof the following section:

“SECTION 34. Chapter 1760 is hereby amended by inserting after section 5 the following section:—

Section 5C. (a) A contract or agreement between a carrier and a health care provider, including a hospital, physician group practice or imagining service, entered or renewed on or after January 1, 2012, shall adhere to the following:

(1) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, greater than or equal to 10 per cent above the carrier’s statewide adjusted average in the previous year beginning October 1 through September 30 shall not increase rates to be paid under that contract beyond the prior year’s existing rate.

(2) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, greater than zero per cent but lower than 10 per cent above the carrier’s statewide adjusted average in the previous year beginning October 1 through September 30 shall not increase rates to be paid under that contract by a percentage greater than the 12 month projected change of the United States city average Consumer Price Index for Medical Care Services for the following year.

(3) A carrier with a contract for payment between the carrier and a health care provider containing a rate, adjusted for volume and acuity, between zero per cent and 10 per cent below the carrier’s statewide adjusted average in the previous year beginning October 1 through September 30 shall increase rates to be paid under that contract by a percentage greater than the 12 month projected change of the United States city average Consumer Price Index for Medical Care Services for the following year. These contracts shall not increase by a percentage more than the 1.5 times the 12 month projected change of the United States city Consumer Price Index for Medical Care Services for the following year.

(4) A carrier with a contract for payment between the carrier and health care provider containing a rate, adjusted for volume and acuity, greater than 10 per cent below the carrier’s statewide adjusted average in the previous year beginning October 1 through September 30 shall increase rates to be paid under that contract by a percentage more than 1.5 times the twelve month projected change of the United States city Consumer Price Index for Medical Care Services for the following year.

(b) Notwithstanding subsection (a) the division of insurance, in consultation with the division of health care finance and policy, may by regulation establish rate factors based on statistically sound analysis of the differences in the cost of providing health care services for different rate factor categories of health care provider, including, but not limited to, disproportionate share status, specialty, pediatric specialty, academic status and geographic location. A carrier may enter into or renew a contract on or after January 1, 2012 under which the carrier agrees to pay the health care provider a rate that applies an applicable rate factor established under this section; provided, however, that the resulting rate shall not be greater than 30 per cent above or greater than 30 per cent below the carrier’s

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statewide adjusted average for all health care providers, regardless of whether the rate factor applies to the carrier or not.

(c) All contracts between a carrier and provider as defined in this section shall be filed with the division of insurance. The division may specify, by regulation, categories of information which may be furnished under an assurance of confidentiality to the provider. The division may review all contracts and shall refer any contracts deemed non-compliant to the attorney general.

(d) The division of insurance shall promulgate such regulations as may be necessary to ensure compliance with this section. The division of health care finance and policy shall publish carrier and aggregate statewide adjusted averages, rate factors and applicable consumer price index projections on an annual basis.

(e) Annually, on April 1, carriers shall submit an annual report to the division of health care finance and policy and to the division of insurance that identify all savings from reductions or mitigations in the growth of provider prices for the prior calendar year. The noted savings shall be certified by an actuary independent of the carrier. The division of health care finance and policy shall assess carriers 50 percent of the savings identified in these reports to deposit in the Disproportionate Share Hospital Trust Fund, established in section 35MM of chapter 10, and shall distribute the proceeds of this fund annually to those hospitals meeting the definition of a disproportionate share hospital, as defined in section 1 of 118G, based on the hospital's prior year share of uncompensated care in the commonwealth. The division of health care finance and policy shall promulgate such regulations as may be necessary to ensure compliance with this subsection.

(f) Fifty per cent of the savings identified subsection (e) shall be incorporated as savings in premiums charged to health plan members.

(g) Not later than January 2012, the division of insurance, in consultation with the executive office of health and human services, shall determine the formula for carriers to use in complying with the requirements of this section. The division shall analyze the differences between a carrier's median, weighted average or un-weighted average and shall promulgate regulations requiring the use of either the median, weighted average or un-weighted average as the single standard formula across all carriers. The division in promulgating these regulations shall ensure that the standard formula used achieves the combined goals of maximizing reduction in premiums and reducing the disparities in what the highest and lowest reimbursed providers are paid.

(h) Provided that contracts between a carrier and a provider that automatically renew year to year shall be excluded from this section.

(i) Provided that the rates paid to a pediatric hospital as defined in c. 118G, Section 1 and its affiliated physicians shall be compared to the rates paid to pediatric hospitals of similar size and scope rather than to a statewide average rate"; and by striking out section 63 (as printed) and inserting in place thereof the following section:

“SECTION 66. Section 35 shall take effect on December 31, 2015.”.

The amendments were adopted.

Mr. deMacedo of Plymouth then moved to amend the bill by adding the following section:

“SECTION 79. Notwithstanding any general or special law to the contrary, there shall be a special commission on small group rate regulation in Massachusetts. The commission shall consist of the chairpersons of the Joint Committee on Financial Services, who shall serve as co-chairs, the commissioner of insurance, the

executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, 1 person to be appointed by the Minority Leader of the House, and 1 person to be appointed by the Minority Leader of the Senate, and 6 members to be appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and 1 of whom shall be an actuary in good standing with the American Society of Actuaries, and 1 of whom shall be a health economist. The commission shall conduct a study of the small group rate regulation environment in Massachusetts. The study shall include analysis of the use of a presumptive disapproval standard, the short term and long term impact on small group premium rates and the potential impact on the health care industry of disapproving rates filed at a minimum level necessary to cover actual medical costs, as well as issues of carrier solvency. The commission shall hold its first meeting no later than October 1, 2010, and shall issue a report of its findings, including recommended policy changes, if any, with the clerks of the senate and the house of representatives and with the governor not later than July 31, 2011.”.

The amendment was rejected.

Mr. Perry of Sandwich and other members of the House then moved to amend the bill by adding the following three sections:

“SECTION 79. Chapter 112 of the Massachusetts General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out section 12C and inserting in place thereof the following section:-

Section 12C. No physician or nurse administering immunization or other protective programs under public health programs shall be liable in a civil suit for damages as a result of any act or omission on his part in carrying out his duties. No physician or nurse who is registered by the Commonwealth in the Massachusetts System for Advance Registration of Volunteer Health Professionals or its successor entity shall be liable in civil suit for damages for any act or omission on his part related to his voluntary participation in any disaster preparedness or response activity.

SECTION 80. Section 60H of chapter 231 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out, in lines 6, 13 and 14, 21, and 23, in each instance, the words ‘five hundred thousand’ and inserting in place thereof in each instance the figures:- \$250,000.

SECTION 81. Said chapter 231, as so appearing, is hereby amended by adding after section 60K, the following new sections:

Section 60L. In any action for malpractice, error or mistake against a provider of health care licensed pursuant to section 2 of chapter 112, as most recently amended by Chapter 305 of the Acts of 2008, including actions pursuant to section 60B of this chapter, an expert witness shall be board certified in the same specialty as the defendant licensed pursuant to section 2 of chapter 112, as so appearing.

Section 60M. In every action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care the court may, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds \$50,000 in future damages. In entering a judgment

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ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages, and court shall require a defendant who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the defendant.

(a)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the defendant has exhibited a continuing pattern of failing to make the payments as specified in paragraph (1), the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(b) Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to his death, or to whom the plaintiff assigned, transferred, or bequeathed his right to receive payment. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(c) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the defendant to make future payments shall cease and any security given, pursuant to this section shall revert to the defendant.

Section 60N. In any action for malpractice, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care, the liability of each defendant for damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount."

After debate on the question on adoption of the amendment, the sense of the House was taken by yeas and nays at the request of Mr. Perry; and on the roll call 24 members voted in the affirmative and 129 in the negative.

Amendment  
rejected,—  
yea and nay  
No. 454.

**[See Yea and Nay No. 454 in Supplement.]**

[Mr. Madden of Nantucket answered "Present" in response to his name.]

Therefore the amendment was rejected.

Mr. Walsh of Lynn and other members of the House then moved to amend the bill by adding the following two sections:

"SECTION 79. Section 1 of Chapter 176J of the General Laws is hereby amended by inserting the following two definitions:

'Small business health plan', a Massachusetts nonprofit or not-for-profit corporation all the members of which are qualified associations and that negotiates with one or more carriers for the issuance of health benefit plans that cover employees of qualified association members and their dependents.

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

SECTION 80. Chapter 176J of the General Laws is hereby amended by adding at the end thereof the following new section:

Section 11. Small Business Health Plans

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

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

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

(d) Health care coverage procured by a small business health plan shall be sold to qualified association members.

(e) Eligible businesses for the small business health plan shall have not more than 50 eligible employees.

(f) The Commissioner shall report on the effectiveness and business cost savings to the Committees on Senate Ways and Means and House Ways and Means as well as the Joint Committees on Health Care Financing and Financial Services within 48 months of the initial certification of the small business health plan as defined under this section.”.

After debate on the question on adoption of the amendment, the sense of the House was taken by yeas and nays at the request of Mr. Murphy of Weymouth; and on the roll call 151 members voted in the affirmative and 1 in the negative.

Amendment  
adopted,—  
yea and nay  
No. 455.

**[See Yeas and Nays No. 455 in Supplement.]**

Therefore the amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill by adding the following four sections:

“SECTION 81. Paragraph (n) of section 5 of chapter 614 of the acts of 1968 is hereby amended by striking out the words ‘its administrative’ and inserting in place thereof the following words:- fees, administrative.

SECTION 82. Said section 5 of said chapter 614 is hereby further amended by inserting after paragraph (n) the following paragraph:-

(n1/2) to fund the capital reserves authorized under paragraph (g) of section 10, to fund and administer loans and grant programs for community hospitals and community health centers under paragraph (g) of section 10 and to fund any reimbursement of the commonwealth required by paragraph (g)(xii) of section 10;.

SECTION 83. Section 10 of said chapter 614 is hereby further amended by

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adding the following paragraph:-

(g)(i) For the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health and meeting the definition of a community health center under 114.6 CMR 13.00 as either a community health center or a hospital licensed health center, the authority may create and establish special funds to be known as Community Hospital and Community Health Center Capital Reserve Funds and, to the extent so created, shall pay into each such fund any monies appropriated and made available by the commonwealth for the purposes of such fund, any proceeds from the sale of notes or bonds to the extent provided in the resolution, trust agreement or indenture of the authority authorizing issuance thereof, any other monies or funds of the authority that the authority determines to deposit in the fund and any other monies which may be available to the authority only for the purpose of such fund from any other source or sources. All monies held in the fund, except as hereinafter provided, shall be used solely for the payment of the principal of bonds of the authority which are secured by any such fund as the same mature, which herein shall include becoming payable by sinking fund installment, the purchase of such bonds, the payment of interest on such bonds, or the payment of any redemption premium required to be paid when such bonds are redeemed prior to maturity; provided, however, that, monies in a Community Hospital and Community Health Center Capital Reserve Fund shall not be withdrawn therefrom at any time in such amount as would reduce the amount of the fund to less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on outstanding bonds which are secured by the fund, except for the purpose of paying the principal of and interest on such bonds maturing and becoming due or for the retirement of such bonds in accordance with the terms of a contract between the authority and its bondholders and for the payment of which other monies pledged to secure such bonds are not available. Any income or interest earned by, or increment to, a Community Hospital and Community Health Center Capital Reserve Fund due to the investment thereof shall be used by the authority for the purposes of the fund. (ii) The authority shall not issue bonds which are secured by a Community Hospital and Community Health Center Capital Reserve Fund at any time if the maximum amount of principal and interest maturing or becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by a fund will exceed the amount of such Community Hospital and Community Health Center Capital Reserve Fund at the time of issuance unless the Authority, at the time of issuance of such bonds, shall deposit in such Fund from the proceeds of the bonds so to be issued, or otherwise, an amount which, together with the amount then in the fund, will be not less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by any such fund. (iii) To assure the continued operation and solvency of the authority for the carrying out of the public purposes of this act, provision is made in subparagraph (i) for the accumulation in a Community Hospital and Community Health Center Capital Reserve Fund of an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on all outstanding bonds which are secured by any such fund. In order to further assure the maintenance of a Community Hospital and Community Health Center Capital Reserve Fund, there shall be appropriated annually and paid to the authority for deposit in the fund such sum, if any, as shall

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be certified by the executive director of the authority to the governor as necessary to restore the fund to an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on the outstanding bonds which are secured by any such fund. The executive director of the authority shall annually, on or before December 1, make and deliver to the governor a certificate stating the amount, if any, required to restore a Community Hospital and Community Health Center Capital Reserve Fund to the amount aforesaid and the amount so stated, if any, shall be appropriated and paid to the authority during the then current fiscal year of the commonwealth. (iv) For the purposes of this paragraph, in computing the amount of a Community Hospital and Community Health Center Capital Reserve Fund, securities in which all or a portion of the fund are invested shall be valued at par or, if purchased at less than par, at their cost to the authority unless otherwise provided in the resolution, trust agreement or indenture authorizing the issuance of bonds secured by the fund. (v) For the purposes of this paragraph, the amount of a letter of credit, insurance contract, surety bond or similar financial undertaking available to be drawn upon and applied to obligations to which money in the Community Hospital and Community Health Center Capital Reserve Fund may be applied shall be counted as money in the fund. For the purposes of this paragraph, in calculating the maximum amount of interest due in the future on variable rate bonds or bonds with respect to which the interest rate is not at the time of calculation determinable, the interest rate shall be calculated at the maximum interest rate on such bonds or such lesser interest rate as shall be certified by the authority as an appropriate proxy for such variable or nondeterminable interest rate. (vi) Bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund shall be issued by the authority solely for the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health. (vii) Notwithstanding any provision of this act to the contrary, no loan shall be made by the authority to a nonprofit community hospital or nonprofit community health center from the proceeds of bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund established under this paragraph unless: (a) the project to be financed by the loan has been approved by the secretary of health and human services; and (b) the loan and the issuance and terms of the related bonds have been approved by the secretary of administration and finance. In connection with any loan to a nonprofit community hospital or nonprofit community health center pursuant to this paragraph, the secretary of health and human services and the secretary of administration and finance may enter into an agreement with the authority and the nonprofit community hospital or nonprofit community health center to: (a) require that the nonprofit community hospital or nonprofit community health center provide financial statements or other information relevant to the financial condition of the nonprofit community hospital or nonprofit community health center and its compliance with the terms of the loan; (b) require that the nonprofit community hospital or nonprofit community health center reimburse the commonwealth for any amounts the commonwealth transfers to the fund under subparagraph (iii) to replenish the fund as a result of a loan payment default by the nonprofit community hospital or nonprofit community health center; and (c) require compliance by the nonprofit community hospital or nonprofit community health center or the authority with any other terms and conditions that the secretary of health and human services and the secretary of administration and finance considers appropriate in connection with the loan. (viii) When the authority notifies the

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secretary of administration and finance in writing that an institution eligible to use the authority under this paragraph is in default as to the payment of principal or interest on any bonds issued by the authority on behalf of that institution or that the authority has reasonable grounds to believe that the institution will not be able to make a full payment when that payment is due, the secretary of administration and finance shall direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the institution until the amount of the principal or interest due or anticipated to be due has been paid to the authority or the trustee for the bondholders, or until the authority notifies the secretary of administration and finance that satisfactory arrangements have been made for the payment of the principal and interest. Funds subject to withholding under this subparagraph shall include, but not be limited to, federal and state grants, contracts, allocations and appropriations. (ix) If the authority further notifies the secretary of administration and finance in writing that no other arrangements are satisfactory, the secretary shall direct the comptroller to make available to the authority without further appropriation any funds withheld from the institution under subparagraph (viii). The authority shall apply the funds to the costs incurred by the institution, including payments required to be made to the authority or trustee for any bondholders of debt service on any bonds issued by the authority for the institution or payments to replenish the Community Hospital and Community Health Center Capital Reserve Fund or required by the terms of any other law or contract to be paid to the holders or owners of bonds issued on behalf of the institution upon failure or default, or upon reasonable expectation of failure or default, of the institution to pay the principal or interest on its bonds when due. (x) Concurrent with any notice from the authority to the secretary of administration and finance under this paragraph, the authority may notify any other agency, department or authority of state government that exercises regulatory, supervisory or statutory control over the operations of the institution. Upon notification, the agency, department or authority shall immediately undertake reviews to determine what action, if any, that agency, department or authority should undertake to assist in the payment by the institution of the money due or the steps that the agencies of the commonwealth, other than the comptroller or the authority, should take to assure the continued prudent operation of the institution or provision of services to the people served by the institution. (xi) Notwithstanding any general or special law to the contrary, in the event that a nonprofit community hospital or nonprofit community health center fails to reimburse the commonwealth for any transfers made by the commonwealth to the authority to replenish the Community Hospital and Community Health Center Capital Reserve Fund in accordance with subparagraph (iii) within 6 months after any such transfer and as otherwise provided in accordance with the terms of the agreement among the nonprofit community hospital or nonprofit community health center, the authority and the commonwealth authorized under subparagraph (vii), the secretary of administration and finance may, in his sole discretion, direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the nonprofit community hospital or nonprofit community health center to cover all or a portion of the amount the nonprofit community hospital or nonprofit community health center has failed to pay to the commonwealth to reimburse the commonwealth for any such transfers. All contracts issued by the group insurance commission, the commonwealth health insurance connector authority and MassHealth to a third party for the purposes of providing health care insurance paid for by the commonwealth shall provide that, at the direction of the

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secretary of administration and finance, the third party shall withhold payments to a nonprofit community hospital or nonprofit community health center which fails to reimburse the commonwealth in accordance with the agreement authorized under subparagraph (vii) and shall transfer the withheld amount to the commonwealth. Any such withheld amounts shall be considered to have been paid to the nonprofit community hospital or nonprofit community health center for all other purposes of law and the nonprofit community hospital or nonprofit community health center shall be considered to have reimbursed the commonwealth for all or a portion of any such transfers to the Community Hospital and Community Health Center Capital Reserve Fund for purposes of the agreement authorized under said subparagraph (vii). (xii) Notwithstanding any general or special law to the contrary, in the event that the commonwealth has not been fully reimbursed the amount of any transfer made pursuant to this subsection (g) as of the one year anniversary of such transfer, the authority shall pay to the commonwealth an amount equal to that portion of the transfer for which the commonwealth has not yet received reimbursement as of said anniversary. Said reimbursement shall be completed pursuant to a schedule determined by the secretary of administration and finance. Said reimbursement shall not interfere with the obligations of a nonprofit community hospital or nonprofit community health center pursuant to subsection (g) (xi). Any funds received by the commonwealth pursuant to subsection (g) (xi) which exceed the full reimbursement to the commonwealth from the authority required by this subsection (g) (xii), shall be paid to the authority. (xiii) For the purposes of this paragraph, a community hospital or community health center shall not include a hospital where the ratio of the number of physician residents in training to the number of inpatient beds exceeds 0.25.

SECTION 84. Section 12 of said chapter 614 is hereby amended by striking out the last sentence and inserting in place thereof the following sentence: Except as otherwise provided in paragraph (g) of section 10, the issuance of revenue bonds under this act shall not directly, indirectly or contingently obligate the commonwealth or any political subdivision thereof to levy or to pledge any form of taxation therefore or to make any appropriation for payment of those bonds.”

The amendment was adopted.

Messrs. Conroy of Wayland and Mariano of Quincy then moved, there being no objection, to amend the bill by striking out section 28 (as previously amended) and inserting in place thereof the following section:

“SECTION 28. Said Chapter 176J is hereby amended by striking out section 6 and inserting in place thereof the following section:—

Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan’s overall network. The commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require that health insurance policies that exclude mandated benefits shall only be offered to small businesses which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall also provide that small businesses shall not have any health insurance policies that exclude mandated benefits for more than a 5-year period.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small

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businesses and eligible individuals to submit information as required by the commissioner, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including, but not limited to, adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses, including, but not limited to, disease management, utilization review and medical management;

(v) network operations expenses, including, but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including, but not limited to, contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clauses (i) to (ix), inclusive.

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

(d) For base rate changes filed to be effective between October 1, 2010 and June 30, 2012, inclusive, if a carrier files a base rate whose administrative expense loading component increases by more than the most recent calendar year's percentage increase in the New England medical CPI or if a carrier's reported contribution to surplus exceeds 1.9%, such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection, with the exception of any carrier whose Risk Based Capital Ratio falls below 300% for the most recent four consecutive quarters. For such carriers the reported contribution to surplus may not exceed 2.5%.

(e) If a proposed base rate change has been presumptively disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

The commissioner shall adopt regulations to specify the scheduling of the hearings required pursuant to this subsection.

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(f) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The carrier may request a hearing on the disapproval by filing a written request with the division of insurance within 10 days of its receipt of such notice."

The amendment was adopted.

Messrs. Alicea of Charlton and Mariano of Quincy then moved amend the bill by adding the following section:

"SECTION 85. Chapter 111 of the General Laws is hereby amended by adding, after Section 24I, the following new section:—

Section XX. (a) The department shall conduct a study to determine the cost effectiveness of allowing eligible health care providers that participate in the Massachusetts Department of Public Health (MDPH) Immunization Program to select any FDA approved vaccine for use in an eligible patient, including combination vaccines and any dosage forms that:

(1) are recommended by the federal Advisory Committee on Immunization Practices or any successor committee serving a comparable function, for use in a particular patient population;

(2) are made available to the Department by the Centers for Disease Control and Prevention of the United States Public Health Service

(b) The Department shall also conduct a study to determine the cost effectiveness to allow the usage of a single preferred product for use in the Massachusetts Department of Public Health Immunization Program where equivalent vaccines exist if the cost to the department of providing the vaccine is more than 115 percent of the lowest priced equivalent vaccine. For the purposes of this section, 'equivalent vaccines' means two or more vaccines that meet all of the following:

(1) protect a recipient of a vaccine against the same infection or infections;

(2) require the same number of doses;

(3) have similar safety and efficacy profiles;

(4) are recommended for comparable populations by the Centers for Disease Control and Prevention of the United States Public Health Service."

The amendment was adopted.

On the question on passing the bill, as amended, to be engrossed, in concurrence, the sense of the House was taken by yeas and nays at the request of Mr. Mariano of Quincy; and on the roll call 138 members voted in the affirmative and 15 in the negative.

**[See Yeas and Nays No. 456 in Supplement.]**

Therefore the bill, as amended, was passed to be engrossed, in concurrence (for House text, as amended, see House document numbered 4924, published as amended). The bill (Senate, No. 2447, amended) then was sent to the Senate for concurrence in the House amendment.

*Emergency Measure.*

The engrossed Bill establishing a sick leave bank for Sharon Baert, an employee of the Department of Developmental Services (see Senate, No. 2466, amended), having been certified by the Clerk to be rightly and truly prepared for final passage, was considered, the question being on adopting the emergency preamble.

Bill passed to be engrossed,—  
yea and nay  
No. 456.

Sharon Baert, —  
sick leave bank.

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A separate vote was taken, as required by the provisions of Article XLVIII (as amended by Article LXVII) of the Amendments to the Constitution; and the preamble was adopted, by a vote of 32 to 0. Sent to the Senate for concurrence.

Subsequently, the Senate having concurred in adoption of the emergency preamble, the bill (which originated in the Senate) was passed to be enacted; and it was signed by the acting Speaker and Senate to the Senate.

*Engrossed Bill.*

The engrossed Bill relative to kayak safety (see Senate, No. 2518) (which originated in the Senate), having been certified by the Clerk to be rightly and truly prepared for final passage, was put upon its final passage.

Kayak  
safety.

Pending the question on passing the bill to be enacted, Mr. Straus of Mattapoisett moved that Rule 40 be suspended; and the motion prevailed. The same member then moved to amend the bill by striking out section 3 and inserting in place thereof the following section:

“SECTION 3. Said section 5A of said chapter 90B, as so appearing, is hereby further amended by inserting in the first sentence after the word ‘vessel’ the following:— including canoes and kayaks.”.

The amendment was adopted. Sent to the Senate for concurrence.

*Order.*

On motion of Mr. DeLeo of Winthrop,—

*Ordered,* That when the House adjourns today, it adjourn to meet on Monday next at eleven o’clock A.M.

Next  
sitting.

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Accordingly, without further consideration of the remaining matters in the Orders of the Day, at twenty-seven minutes before seven o’clock P.M. (Thursday, July 22), on motion of Mr. Pedone of Worcester (Mr. Murphy of Burlington being in the Chair), the House adjourned, to meet the following Monday at eleven o’clock A.M., in an Informal Session.