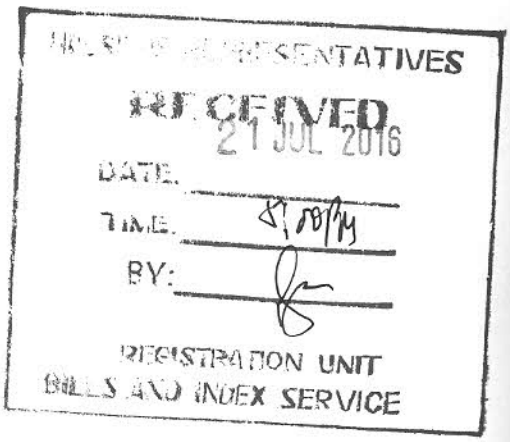
Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City

SEVENTEENTH CONGRESS
First Regular Session

HOUSE BILL NO. 1851



INTRODUCED BY CONGRESSMAN ALFREDO D. VARGAS III

EXPLANATORY NOTE

Breast cancer is the most common type of cancer in the country and is the primary cause of death among Filipino women[1]. With one out of every 13 Filipinas expected to develop breast cancer in her lifetime, the Philippines ranks first in breast cancer incidences in Asia.[2]

It is important to note, however, that breast cancer is preventable and curable. Through early screening and detection, coupled with proper treatment, the physical, emotional, and economic consequences of being afflicted by breast cancer can be prevented. Thus, it is critical that breast cancer patients are given the maximum benefits and opportunities.

This bill seeks to require health insurance companies to provide coverage in their plans for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer. Furthermore, it also requires coverage for secondary consultations.

Through this initiative, not only do we give breast cancer patients better chances of healing and survival but we are also sparing their families from dealing with the physical, emotional and financial burdens that cancer brings to the family.

In view of the foregoing, the passage of this bill is earnestly sought.

ALFREDO D. VARGAS III

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[1] Philip C. Tubeza. *Breast cancer is the most prevalent in PH.* Philippine Daily Inquirer. Available at: http://newsinfo.inquirer.net/291078/breast-cancer-is-the-most-prevalent-in-ph [21 October 2015]

[2] Inquirer.net. *PH highest breast cancer incidence rate in Asia, health experts say.* Available at: http://lifestyle.inquirer.net/128663/ph-highest-breast-cancer-incidence-rate-in-asia-health-experts-say [21 October 2015]

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AN ACT
REQUIRING HEALTH INSURANCE COMPANIES TO PROVIDE COVERAGE IN THEIR MEDICAL INSURANCE PLAN FOR A MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTION FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS

Be it enacted by the Senate and the House of Representatives of the Philippines in Congress assembled:

Section 1. ***Short Title.*** – This Act shall be known as the "Breast Cancer Patient Protection Act."

Section 2. ***Declaration of Policy.*** –It is the policy of the State to protect and promote the right to health of the people and instill health consciousness among them.

Section 3. ***Definition of Terms.*** – As used in this Act, the term;

1. "Breast cancer" means a type of malignant growth in the breast tissue;
2. "DOH" means the Department of Health;
3. "Health plan" means a medical insurance plan provided by a health insurance company to certain groups in order to provide them with medical and surgical benefits;
4. "Lumpectomy" means a medical operation that removes a lump from the breast;
5. "Lymph node" means rounded mass of lymphatic issue that is surrounded by a capsule of connective tissue;
6. "Mastectomy" means medical operation that removes a woman's breast; and
7. "Secretary" means the DOH Secretary.

Section 4. ***Required Coverage for Minimum Hospital Stay for Mastectomies, Lumpectomies, and Lymph Node Dissections for the Treatment of Breast Cancer and Coverage for Secondary Consultations. –***

1. *In-patient Care.* –
   A. *In General.* – A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides medical and surgical benefits shall ensure that the in-patient, and in the case of a lumpectomy, the out-patient coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not, except as provided for in paragraph (B) –

      a. Restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery, such as a lumpectomy, for the treatment of breast cancer to less than 48 hours;
      b. Restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours; or
      c. Require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under Subparagraph (1) without regard to paragraph (B)

   B. *Exception.* – Nothing in this Section shall be construed as requiring the provision of in-patient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or out-patient treatment, is medically appropriate.

2. *Prohibition on Certain Modifications.* – In implementing the requirements of this Section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under paragraph (A).

3. *Notice.* – A group health plan and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted in the next mailing made by the plan or issuer to the participant or beneficiary; whichever is earlier.

Section 5. ***Secondary Consultations.*** –

1. *In General.* – A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields, including pathology, radiology, and oncology, whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation is not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

2. *Exception.* – Nothing in paragraph (A) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

Section 6. ***Prohibition on Penalties or Incentives.*** – A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not –

1. Penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this Section;
2. Provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;
3. Provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under Section 5; or
4. Deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage solely for the purpose of avoiding the requirements of this Section.

Section 7. ***Effective Dates.*** –

1. *In General.* – The amendments made by this section shall apply to group health plans for plan years beginning on or after 90 days after the date of enactment of this Act.
2. *Special Rule for Collective Bargaining Agreements.* – In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates, determined without regard to any extension thereof agreed to after the date of enactment of this Act. For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

Section 8. ***Separability Clause.*** –If any provision of this Act is held invalid or unconstitutional, the same shall not affect the validity and effectivity of the other provisions hereof.

Section 9. ***Repealing Clause.*** – All laws, decrees, orders, and issuances, or portions thereof, which are inconsistent with the provisions of this Act, are hereby repealed, amended or modified accordingly.

Section 10. ***Effectivity Clause.*** – This Act shall take effect fifteen (15) days after its publication in the *Official Gazette* or in two (2) newspapers of general circulation.

Approved,