THIRTEENTH CONGRESS OF THE REPUBLIC )
OF THE PHILIPPINES )
First Regular Session )



SENATE
S. B. No. 2019

Introduced by Senator Miriam Defensor Santiago

EXPLANATORY NOTE

The Constitution, Article 2, Section 15, provides:

> The State shall protect and promote the right to health of the people and instill health consciousness among them.

Every woman dreads the thought of being diagnosed with breast cancer. According to the National Cancer Institute of the National Institutes of Health of the United States, more than half a million women worldwide are diagnosed annually with breast cancer. Even though breast cancer is more common in older women, it also occurs in younger women and even in a small number of men.

Breast cancer is the second leading type of cancer for both sexes in the Philippines. In fact, it ranks first among women and the country has the highest incidence of breast cancer in Asia. In 1998, it was estimated that 9,325 new cases were diagnosed and 3,057 women died of breast cancer.

There is no known primary prevention method against breast cancer. This means that there is no efficient method to prevent breast cancer from developing. There are, however, effective secondary prevention methods or ways to detect or screen for breast cancer at an early stage. Detection at an early stage should be followed by early treatment, which eventually results to decreased mortality from the disease.

Breast cancer can be cured when detected early and given the proper treatment This bill seeks to require that health plans provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations.

MIRIAM DEFENSOR SANTIAGO

THIRTEENTH CONGRESS OF THE REPUBLIC )
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AN ACT
TO REQUIRE THAT HEALTH PLANS PROVIDE COVERAGE 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 of 2005."

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:

(a) "Breast cancer" – refers to any type of malignant growth in the breast tissue.

(b) "Health plan" – refers to a medical insurance plan provided by a health insurance issues to certain groups in order to provide the them with medical and surgical benefits.

(c) "Mastectomy" – refers to a medical operation that removes a woman's breast.

(d) "Lumpectomy" – refers to a medical operation that removes a lump from the breast.

(e) "Lymph node" – refers to rounded mass of lymphatic tissue that is surrounded by a capsule of connective tissue.

(f) "DOH" – refers to the Department of Health.

(g) "Secretary" – refers to 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.* —

(a) INPATIENT CARE. —

(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 medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not —

(A) except as provided for in paragraph (2) —

(i) 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; or

(ii) 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

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION. — Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

(b) 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 subsection (a).

(c) 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 and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

(2) as part of any yearly informational packet sent to the participant or beneficiary;

whichever is earlier.

SECTION 5. *Secondary Consultations.*—

(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 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) provided for such secondary consultation 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 are 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.

(b) 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—

(a) 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;

(b) 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;

(c) 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

(d) 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.* —

(a) 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.

(b) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS. — In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 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, or part hereof is held invalid or unconstitutional, the remainder of the law or the provision not otherwise affected shall remain valid and subsisting.

SECTION 9. *Repealing Clause.* — Any law, presidential decree or issuance, executive order, letter of instruction, administrative order, rule or regulation contrary to or inconsistent with the provisions of this Act is hereby repealed, modified or amended accordingly.

SECTION 10. *Effectivity Clause.* — This Act shall take effect fifteen (15) days after its publication in at least two (2) newspapers of general circulation.

Approved,

/jpa