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HOUSE . . . . . No. 3559

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act relative to the continuity of care of mental health treatment.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 1 of chapter 176O of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting after the definition of "Concurrent review" the following definition:-

"Continuing course of treatment", having at least one visit in the past four months for the same or similar mental health diagnosis or set of symptoms.

SECTION 2. Section 15 of said chapter 176O, as so appearing, is hereby amended by striking out the title "Continued treatment by involuntarily disenrolled physicians and providers; specialty health care coverage" and inserting in place thereof the following title:-

Continued treatment by out-of-network physicians and providers; specialty health care coverage.

SECTION 3. Section 15 of said chapter 176O, as so appearing, is hereby further amended by inserting after subsection (k) the following subsection:-

(l) A carrier shall allow any insured who is engaged in a continuing course of treatment with a licensed mental health provider eligible for coverage under the plan, and whose provider in connection with said mental health treatment is involuntarily or voluntarily disenrolled, other than for quality-related reasons or for fraud, or whose carrier has changed for any reason thereby placing the provider out-of-network, to continue treatment with said provider through an out-of-network option, pursuant to the following:

(1) The carrier shall reimburse the licensed mental health care professional the usual network per-unit reimbursement rate for the relevant service and provider type as payment in full. If more than one reimbursement rate exists, the carrier shall use the median reimbursement rate.

(2) The non-network option may require that a covered person pay a higher co-payment only if the higher co-payment results from increased costs caused by the use of a non-network provider. The carrier shall provide an actuarial demonstration of the increased costs to the division of health care finance and policy at the commissioner's request. If the increased costs are not justified, the commissioner shall require the carrier to recalculate the appropriate costs allowed and resubmit the appropriate co-payment to the division of health care finance and policy.

(3) No additional charges, costs or deductibles may be levied due to the exercise of the out-of-network option. The amount of any additional co-payment charged by the carrier for the additional cost of the creation and maintenance of coverage described in subsection (1) of this section shall be paid by the covered person unless it is paid by an employer or other person through agreement with the carrier.

SECTION 4. Subsection (e) of section 15 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 37-38, the words “that could have been imposed if the provider had not been disenrolled;” and inserting the following words:- permitted under this section;

SECTION 5. Subsection (e) of section 15 of said chapter 176O, as so appearing, is hereby further amended by striking out, in line 45, the word “remained” and inserting the following words:- had been