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SENATE . . . . . No. 2147

Message from His Excellency the Governor (pursuant to Article LVI, as amended by Article XC, Section 3 of the Amendments to the Constitution of the Commonwealth of Massachusetts) returning with recommendation of amendment

The Commonwealth of Massachusetts

OFFICE OF THE GOVERNOR
COMMONWEALTH OF MASSACHUSETTS
· , MA

February 21, 2012

Pursuant to Article LVI, as amended by Article XC, Section 3 of the Amendments to the Constitution, I am returning to you for amendment Sections 17, 18, 19, 20, 46 and 55 of Senate Bill No. 2112, "An Act making appropriations for the fiscal year 2012 to provide for supplementing certain existing appropriations and for certain other activities and projects."

Sections 17, 18, 19, 20, 46 and 55 require health plans to cover certain services for individuals who are in the small and non-group health insurance market, and who are newly enrolled in a limited or tiered network, if they are undergoing an active course of treatment or follow up treatment for a chronic disease at a comprehensive cancer center, pediatric hospital or specialty unit. I support the general purposes of these sections.

These sections, however, are too broad and need to be narrowed in order to continue to control health care costs and offer affordable health plans to small businesses and individuals. I also recommend delaying their effective date to allow the Division of Insurance time to formulate necessary regulations.

For these reasons, I recommend that Sections 17, 18, 19, 20, 46 and 55 be amended by striking out their text and inserting in place thereof the following text:-

SECTION 17. Chapter 176J of the General Laws is hereby amended by inserting after section 11 the following section:-

Section 11A. (a) For an insured member who (1) is receiving an active course of medical treatment from a health care provider for a serious disease, including but not limited to cancer or cystic fibrosis, that if disrupted in the course of medical treatment would pose an undue hardship to the patient, and (2)(i) began this active course of treatment before being enrolled in a reduced or selective network plan where the provider is not part of the reduced or selective network, or (ii) began this active course of treatment before being enrolled in a tiered network plan where the provider is in the highest cost-sharing tier, the carrier shall provide coverage for those medically necessary and covered services that are part of that active course of treatment provided by that health care provider, to the extent required by subsection (b).

(b) A carrier to which subsection (a) applies shall cover the health care provider's services for the duration of the active course of treatment during the plan year, if (1) the insured's employer offers the insured only a choice of reduced or selective network plans in which the health care provider is not part of any of the offered reduced or selective networks, or a choice of tiered network plans in which the health care provider is in the highest cost-sharing tier; (2) that health care provider is a comprehensive cancer center, pediatric hospital or pediatric specialty unit as defined in section 1 of chapter 118G; and (3) that health care provider is providing the insured with an active course of medical treatment that is not available from another provider in the network of the insured's plan.

(c) For services provided under this section from a provider that is not in the network of the insured's plan, patient cost-sharing shall be at the lowest cost-sharing level applicable to those services in the plan, and reimbursement shall be based on median in-network rates of the specific health care provider in that carrier's private plans in a manner consistent with data filed by that carrier with the division of health care finance and policy; but if the specific health care provider does not participate in any other plan of the carrier, then based on negotiated rates. For services provided under this section by a provider in the highest cost-sharing tier of a tiered network plan, patient cost-sharing shall be based on the second-highest cost-sharing tier in that plan.

(d) The commissioner shall adopt regulations to carry out this section.

SECTION 18. Said chapter 176J is hereby further amended by adding the following 2 sections:-

Section 14. If a medically necessary and covered service is not available to a member within the carrier's provider network, the carrier shall cover the services out-of-network, for as long as the service is unavailable in-network.

Section 15. An insurer offering a tiered network plan shall clearly and conspicuously indicate, in all promotional and agreement materials, the cost-sharing differences for enrollees in the various tiers. The commissioner shall adopt regulations to carry out this section.

SECTION 46. Notwithstanding any general or special law, rule or regulation to the contrary, the division of insurance shall conduct a review of the network adequacy and cost and quality effectiveness of insurance products under section 11 of chapter 176J of the General Laws for the health care needs of children and the health care needs of cancer patients, and shall submit a written report to the house and senate committees on ways and means and the joint committee on health care financing by December 31, 2012. The division shall also adopt regulations to address health plan network adequacy, including access to pediatric and cancer services.

SECTION 55. For an insured member who, before the effective date of this Act, began an active course of medical treatment from a health care provider that is a comprehensive cancer center, pediatric hospital or pediatric specialty unit as defined in section 1 of chapter 118G for a serious disease, including but not limited to cancer or cystic fibrosis, that if disrupted in the course of medical treatment would pose an undue hardship to the patient, and (2)(i) began this active course of treatment before being enrolled in a reduced or selective network plan where the provider is not part of the reduced or selective network, or (ii) began this active course of treatment before being enrolled in a tiered network plan where the provider is in the highest cost-sharing tier, the carrier shall provide coverage for those medically necessary and covered services that are part of that active course of treatment provided by that health care provider until April 30, 2013, notwithstanding subsection (b) of said section 11A, at the patient cost-sharing levels and reimbursement rates required by subsection (c) of said section 11A.

SECTION 55A. This act shall take effect 45 days after the date of passage or upon adoption of regulations by the division of insurance, whichever is earlier.

I approve the remainder of this Act.

Respectfully submitted,

[Executive Name],
[Executive Title]