

111TH CONGRESS
1ST SESSION

H. R. 1691

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.

IN THE HOUSE OF REPRESENTATIVES

MARCH 24, 2009

Ms. DELAURO (for herself, Mr. BARTON of Texas, Mr. ACKERMAN, Mr. ARCURI, Mr. BACA, Ms. BALDWIN, Mr. HILL, Ms. BEAN, Ms. BERKLEY, Mr. BERMAN, Mr. BERRY, Mr. BISHOP of Georgia, Mr. BISHOP of New York, Mr. BLUMENAUER, Ms. BORDALLO, Mr. BOREN, Mr. BOSWELL, Mr. BOYD, Mr. BRADY of Pennsylvania, Ms. CORRINE BROWN of Florida, Mr. BRALEY of Iowa, Mr. BURTON of Indiana, Mr. CAPUANO, Mr. CARDOZA, Mr. CARNEY, Ms. SHEA-PORTER, Mr. CARSON of Indiana, Ms. CASTOR of Florida, Mr. CHANDLER, Mrs. CHRISTENSEN, Mr. CLAY, Mr. CLEAVER, Mr. COHEN, Mr. CONNOLLY of Virginia, Mr. CONYERS, Mr. COOPER, Mr. COURTNEY, Mr. CROWLEY, Mr. CUELLAR, Mr. CUMMINGS, Mr. DAVIS of Illinois, Mr. DAVIS of Tennessee, Mrs. DAVIS of California, Mrs. HALVORSON, Mr. DEFazio, Ms. DEGETTE, Mr. DELAHUNT, Mr. DICKS, Mr. DINGELL, Mr. DOGGETT, Ms. EDWARDS of Maryland, Mr. DOYLE, Mr. EDWARDS of Texas, Mr. ELLISON, Mr. ENGEL, Mr. MASSA, Ms. ESHOO, Mr. ETHERIDGE, Mr. FARR, Mr. FATTAH, Mr. PALLONE, Mr. FRANK of Massachusetts, Mr. GERLACH, Mr. NYE, Mr. GONZALEZ, Mr. GORDON of Tennessee, Mr. AL GREEN of Texas, Mr. GENE GREEN of Texas, Mr. GRIFFITH, Mr. GRIJALVA, Mr. GUTIERREZ, Mr. HARE, Ms. HARMAN, Mr. HASTINGS of Florida, Mr. HIGGINS, Mr. HIMES, Mr. HINCHEY, Mr. HINOJOSA, Ms. HIRONO, Mr. HOLDEN, Mr. HOLT, Mr. INSLEE, Mr. ISRAEL, Mr. JACKSON of Illinois, Ms. JACKSON-LEE of Texas, Mr. MATHESON, Mr. BARROW, Mr. SARBANES, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. KAGEN, Mr. KANJORSKI, Ms. KAPTUR, Mrs. DAHLKEMPER, Mr. MEEK of Florida, Mr. KENNEDY, Mr. KILDEE, Ms. KILPATRICK of Michigan, Ms. KILROY, Mr. KIND, Mr. KLEIN of Florida, Mr. KUCINICH, Mr. LANGEVIN, Mr. LARSEN of Washington, Mr. LARSON of Connecticut, Ms. LEE of California, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LOBIONDO, Mr. LOEBSACK, Ms. ZOE LOFGREN of California, Mrs. CAPPS, Mrs. LOWEY, Mr. LYNCH, Mr. MACK, Mr. MAFFEI, Mrs. MALONEY, Ms. FUDGE, Ms. MATSUI, Mrs. MCCARTHY of New York, Ms. MCCOLLUM, Mr. McDERMOTT, Mr. MCGOVERN, Mr. McHUGH, Mr. McINTYRE, Mr. MEEKS of New York, Mr. MELANCON, Mr. MICHAUD,

Mr. MILLER of North Carolina, Mr. GEORGE MILLER of California, Mr. MOORE of Kansas, Ms. MOORE of Wisconsin, Mr. MORAN of Kansas, Mr. MORAN of Virginia, Mr. MURPHY of Connecticut, Mr. MURTHA, Mrs. MYRICK, Mr. NADLER of New York, Mrs. NAPOLITANO, Ms. NORTON, Mr. OBERSTAR, Mr. OLVER, Mr. ORTIZ, Mr. PASCRELL, Mr. TONKO, Mr. PAYNE, Mr. PETERSON, Ms. PINGREE of Maine, Mr. PLATTS, Mr. PRICE of North Carolina, Mr. RANGEL, Mr. REYES, Mr. RODRIGUEZ, Ms. ROSLEHTINEN, Mr. ROTHMAN of New Jersey, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. RYAN of Ohio, Ms. LINDA T. SÁNCHEZ of California, Ms. SCHAKOWSKY, Mr. SCHIFF, Ms. SCHWARTZ, Mr. SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SESTAK, Mr. SHERMAN, Mr. SIRES, Mr. SKELTON, Ms. SLAUGHTER, Mr. SMITH of Washington, Mr. SNYDER, Mr. SPACE, Ms. SPEIER, Mr. SPRATT, Mr. STARK, Mr. STUPAK, Ms. SUTTON, Mrs. TAUSCHER, Mr. TAYLOR, Mr. THOMPSON of California, Mr. TIERNEY, Mr. TOWNS, Ms. TSONGAS, Mr. VAN HOLLEN, Ms. VELÁZQUEZ, Ms. WASSERMAN SCHULTZ, Mr. WEINER, Mr. WELCH, Mr. WEXLER, Mr. WILSON of Ohio, Mr. WITTMAN, Mr. WOLF, Ms. WOOLSEY, Ms. TITUS, Mr. ALTMIRE, Mr. RUPPERSBERGER, Mr. MCNERNEY, Mr. CLYBURN, Ms. MARKEY of Colorado, Mr. HALL of Texas, Ms. KOSMAS, Mr. ROGERS of Alabama, Mr. FILNER, Mr. SOUDER, and Mr. POLIS of Colorado) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Breast Cancer Patient
 5 Protection Act of 2009”.

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) According to the American Cancer Society,
4 excluding cancers of the skin, breast cancer is the
5 most frequently diagnosed cancer in women.

6 (2) According to the American Cancer Society,
7 an estimated 40,480 women and 450 men died from
8 breast cancer in 2008.

9 (3) According to the American Cancer Society,
10 in 2008 an estimated 182,460 new cases of invasive
11 breast cancer were diagnosed in women, and an esti-
12 mated 1,990 invasive breast cancer cases were diag-
13 nosed in men; and in addition, an estimated 67,770
14 new cases of in situ breast cancer occurred in
15 women in 2008, and of these, approximately 85 per-
16 cent were ductal carcinoma in situ.

17 (4) According to the American Cancer Society,
18 most breast cancer patients undergo some type of
19 surgical treatment, which may involve lumpectomy
20 (surgical removal of the tumor with clear margins)
21 or mastectomy (surgical removal of the breast) with
22 removal of some of the axillary (underarm) lymph
23 nodes.

24 (5) The offering and operation of health plans
25 affect commerce among the States.

1 (6) Health care providers located in a State
2 serve patients who reside in the State and patients
3 who reside in other States.

4 (7) In order to provide for uniform treatment
5 of health care providers and patients among the
6 States, it is necessary to cover health plans oper-
7 ating in one State as well as health plans operating
8 among the several States.

9 (8) Research has indicated that treatment for
10 breast cancer varies according to type of insurance
11 coverage and State of residence.

12 (9) Currently, 20 States mandate minimum in-
13 patient coverage after a patient undergoes a mastec-
14 tomy.

15 (10) Breast cancer patients have reported ad-
16 verse outcomes, including infection and inadequately
17 controlled pain, resulting from premature hospital
18 discharge following breast cancer surgery.

19 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**
20 **COME SECURITY ACT OF 1974.**

21 (a) IN GENERAL.—Subpart B of part 7 of subtitle
22 B of title I of the Employee Retirement Income Security
23 Act of 1974 (29 U.S.C. 1185 et seq.) is amended by add-
24 ing at the end the following:

1 **“SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
2 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
3 **AND LYMPH NODE DISSECTIONS FOR THE**
4 **TREATMENT OF BREAST CANCER AND COV-**
5 **ERAGE FOR SECONDARY CONSULTATIONS.**

6 “(a) INPATIENT CARE.—

7 “(1) IN GENERAL.—A group health plan, and a
8 health insurance issuer providing health insurance
9 coverage in connection with a group health plan,
10 that provides medical and surgical benefits shall en-
11 sure that inpatient (and in the case of a
12 lumpectomy, outpatient) coverage and radiation
13 therapy is provided for breast cancer treatment.
14 Such plan or coverage may not—

15 “(A) insofar as the attending physician, in
16 consultation with the patient, determines it to
17 be medically necessary—

18 “(i) restrict benefits for any hospital
19 length of stay in connection with a mastec-
20 tomy or breast conserving surgery (such as
21 a lumpectomy) for the treatment of breast
22 cancer to less than 48 hours; or

23 “(ii) restrict benefits for any hospital
24 length of stay in connection with a lymph
25 node dissection for the treatment of breast
26 cancer to less than 24 hours; or

1 “(B) require that a provider obtain author-
2 zation from the plan or the issuer for pre-
3 scribing any length of stay required under this
4 paragraph.

5 “(2) EXCEPTION.—Nothing in this section shall
6 be construed as requiring the provision of inpatient
7 coverage if the attending physician, in consultation
8 with the patient, determines that either a shorter pe-
9 riod of hospital stay, or outpatient treatment, is
10 medically appropriate.

11 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
12 In implementing the requirements of this section, a group
13 health plan, and a health insurance issuer providing health
14 insurance coverage in connection with a group health plan,
15 may not modify the terms and conditions of coverage
16 based on the determination by a participant or beneficiary
17 to request less than the minimum coverage required under
18 subsection (a).

19 “(c) NOTICE.—A group health plan, and a health in-
20 surance issuer providing health insurance coverage in con-
21 nection with a group health plan shall provide notice to
22 each participant and beneficiary under such plan regard-
23 ing the coverage required by this section in accordance
24 with regulations promulgated by the Secretary. Such no-
25 tice shall be in writing and prominently positioned in the

1 summary of the plan made available or distributed by the
2 plan or issuer and shall be transmitted—

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

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

7 whichever is earlier.

8 “(d) SECONDARY CONSULTATIONS.—

9 “(1) IN GENERAL.—A group health plan, and a
10 health insurance issuer providing health insurance
11 coverage in connection with a group health plan,
12 that provides coverage with respect to medical and
13 surgical services provided in relation to the diagnosis
14 and treatment of cancer shall ensure that coverage
15 is provided for secondary consultations, on terms
16 and conditions that are no more restrictive than
17 those applicable to the initial consultations, by spe-
18 cialists in the appropriate medical fields (including
19 pathology, radiology, and oncology) to confirm or re-
20 fute such diagnosis. Such plan or issuer shall ensure
21 that coverage is provided for such secondary con-
22 sultation whether such consultation is based on a
23 positive or negative initial diagnosis. In any case in
24 which the attending physician certifies in writing
25 that services necessary for such a secondary con-

1 sultation are not sufficiently available from special-
2 ists operating under the plan with respect to whose
3 services coverage is otherwise provided under such
4 plan or by such issuer, such plan or issuer shall en-
5 sure that coverage is provided with respect to the
6 services necessary for the secondary consultation
7 with any other specialist selected by the attending
8 physician for such purpose at no additional cost to
9 the individual beyond that which the individual
10 would have paid if the specialist was participating in
11 the network of the plan.

12 “(2) EXCEPTION.—Nothing in paragraph (1)
13 shall be construed as requiring the provision of sec-
14 ondary consultations where the patient determines
15 not to seek such a consultation.

16 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
17 A group health plan, and a health insurance issuer pro-
18 viding health insurance coverage in connection with a
19 group health plan, may not—

20 “(1) penalize or otherwise reduce or limit the
21 reimbursement of a provider or specialist because
22 the provider or specialist provided care to a partici-
23 pant or beneficiary in accordance with this section;

24 “(2) provide financial or other incentives to a
25 physician or specialist to induce the physician or

1 specialist to keep the length of inpatient stays of pa-
2 tients following a mastectomy, lumpectomy, or a
3 lymph node dissection for the treatment of breast
4 cancer below certain limits or to limit referrals for
5 secondary consultations; or

6 “(3) provide financial or other incentives to a
7 physician or specialist to induce the physician or
8 specialist to refrain from referring a participant or
9 beneficiary for a secondary consultation that would
10 otherwise be covered by the plan or coverage in-
11 volved under subsection (d).”.

12 (b) CLERICAL AMENDMENT.—The table of contents
13 in section 1 of the Employee Retirement Income Security
14 Act of 1974 is amended by inserting after the item relat-
15 ing to section 714 the following:

“Sec. 715. Required coverage for minimum hospital stay for mastectomies,
lumpectomies, and lymph node dissections for the treatment of
breast cancer and coverage for secondary consultations.”.

16 (c) EFFECTIVE DATES.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply with respect to plan years be-
19 ginning on or after the date that is 90 days after
20 the date of enactment of this Act.

21 (2) SPECIAL RULE FOR COLLECTIVE BAR-
22 GAINING AGREEMENTS.—In the case of a group
23 health plan maintained pursuant to 1 or more collec-
24 tive bargaining agreements between employee rep-

1 “(1) IN GENERAL.—A group health plan, and a
2 health insurance issuer providing health insurance
3 coverage in connection with a group health plan,
4 that provides medical and surgical benefits shall en-
5 sure that inpatient (and in the case of a
6 lumpectomy, outpatient) coverage and radiation
7 therapy is provided for breast cancer treatment.
8 Such plan or coverage may not—

9 “(A) insofar as the attending physician, in
10 consultation with the patient, determines it to
11 be medically necessary—

12 “(i) restrict benefits for any hospital
13 length of stay in connection with a mastec-
14 tomy or breast conserving surgery (such as
15 a lumpectomy) for the treatment of breast
16 cancer to less than 48 hours; or

17 “(ii) restrict benefits for any hospital
18 length of stay in connection with a lymph
19 node dissection for the treatment of breast
20 cancer to less than 24 hours; or

21 “(B) require that a provider obtain author-
22 ization from the plan or the issuer for pre-
23 scribing any length of stay required under this
24 paragraph.

1 “(2) EXCEPTION.—Nothing in this section shall
2 be construed as requiring the provision of inpatient
3 coverage if the attending physician, in consultation
4 with the patient, determines that either a shorter pe-
5 riod of hospital stay, or outpatient treatment, is
6 medically appropriate.

7 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
8 In implementing the requirements of this section, a group
9 health plan, and a health insurance issuer providing health
10 insurance coverage in connection with a group health plan,
11 may not modify the terms and conditions of coverage
12 based on the determination by a participant or beneficiary
13 to request less than the minimum coverage required under
14 subsection (a).

15 “(c) NOTICE.—A group health plan, and a health in-
16 surance issuer providing health insurance coverage in con-
17 nection with a group health plan shall provide notice to
18 each participant and beneficiary under such plan regard-
19 ing the coverage required by this section in accordance
20 with regulations promulgated by the Secretary. Such no-
21 tice shall be in writing and prominently positioned in the
22 summary of the plan made available or distributed by the
23 plan or issuer and shall be transmitted—

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

1 “(2) as part of any yearly informational packet
2 sent to the participant or beneficiary;
3 whichever is earlier.

4 “(d) SECONDARY CONSULTATIONS.—

5 “(1) IN GENERAL.—A group health plan, and a
6 health insurance issuer providing health insurance
7 coverage in connection with a group health plan,
8 that provides coverage with respect to medical and
9 surgical services provided in relation to the diagnosis
10 and treatment of cancer shall ensure that coverage
11 is provided for secondary consultations, on terms
12 and conditions that are no more restrictive than
13 those applicable to the initial consultations, by spe-
14 cialists in the appropriate medical fields (including
15 pathology, radiology, and oncology) to confirm or re-
16 fute such diagnosis. Such plan or issuer shall ensure
17 that coverage is provided for such secondary con-
18 sultation whether such consultation is based on a
19 positive or negative initial diagnosis. In any case in
20 which the attending physician certifies in writing
21 that services necessary for such a secondary con-
22 sultation are not sufficiently available from special-
23 ists operating under the plan with respect to whose
24 services coverage is otherwise provided under such
25 plan or by such issuer, such plan or issuer shall en-

1 sure that coverage is provided with respect to the
2 services necessary for the secondary consultation
3 with any other specialist selected by the attending
4 physician for such purpose at no additional cost to
5 the individual beyond that which the individual
6 would have paid if the specialist was participating in
7 the network of the plan.

8 “(2) EXCEPTION.—Nothing in paragraph (1)
9 shall be construed as requiring the provision of sec-
10 ondary consultations where the patient determines
11 not to seek such a consultation.

12 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
13 A group health plan, and a health insurance issuer pro-
14 viding health insurance coverage in connection with a
15 group health plan, may not—

16 “(1) penalize or otherwise reduce or limit the
17 reimbursement of a provider or specialist because
18 the provider or specialist provided care to a partici-
19 pant or beneficiary in accordance with this section;

20 “(2) provide financial or other incentives to a
21 physician or specialist to induce the physician or
22 specialist to keep the length of inpatient stays of pa-
23 tients following a mastectomy, lumpectomy, or a
24 lymph node dissection for the treatment of breast

1 cancer below certain limits or to limit referrals for
2 secondary consultations; or

3 “(3) provide financial or other incentives to a
4 physician or specialist to induce the physician or
5 specialist to refrain from referring a participant or
6 beneficiary for a secondary consultation that would
7 otherwise be covered by the plan or coverage in-
8 volved under subsection (d).”.

9 (b) EFFECTIVE DATES.—

10 (1) IN GENERAL.—The amendments made by
11 this section shall apply to group health plans for
12 plan years beginning on or after 90 days after the
13 date of enactment of this Act.

14 (2) SPECIAL RULE FOR COLLECTIVE BAR-
15 GAINING AGREEMENTS.—In the case of a group
16 health plan maintained pursuant to 1 or more collec-
17 tive bargaining agreements between employee rep-
18 resentatives and 1 or more employers ratified before
19 the date of enactment of this Act, the amendments
20 made by this section shall not apply to plan years
21 beginning before the date on which the last collective
22 bargaining agreements relating to the plan termi-
23 nates (determined without regard to any extension
24 thereof agreed to after the date of enactment of this
25 Act). For purposes of this paragraph, any plan

1 amendment made pursuant to a collective bargaining
2 agreement relating to the plan which amends the
3 plan solely to conform to any requirement added by
4 this section shall not be treated as a termination of
5 such collective bargaining agreement.

6 **SEC. 4. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT**
7 **RELATING TO THE INDIVIDUAL MARKET.**

8 (a) IN GENERAL.—Subpart 2 of part B of title
9 XXVII of the Public Health Service Act (42 U.S.C.
10 300gg–51 et seq.) is amended by adding at the end the
11 following new section:

12 **“SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
13 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
14 **AND LYMPH NODE DISSECTIONS FOR THE**
15 **TREATMENT OF BREAST CANCER AND SEC-**
16 **ONDARY CONSULTATIONS.**

17 “The provisions of section 2708 shall apply to health
18 insurance coverage offered by a health insurance issuer
19 in the individual market in the same manner as they apply
20 to health insurance coverage offered by a health insurance
21 issuer in connection with a group health plan in the small
22 or large group market.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply with respect to health insurance
25 coverage offered, sold, issued, renewed, in effect, or oper-

1 ated in the individual market on or after the date of enact-
2 ment of this Act.

3 **SEC. 5. AMENDMENTS TO THE INTERNAL REVENUE CODE**
4 **OF 1986.**

5 (a) IN GENERAL.—Subchapter B of chapter 100 of
6 the Internal Revenue Code of 1986 is amended—

7 (1) in the table of sections, by inserting after
8 the item relating to section 9813 the following:

“Sec. 9814. Required coverage for minimum hospital stay for mastectomies,
lumpectomies, and lymph node dissections for the treatment of
breast cancer and coverage for secondary consultations.”;

9 and

10 (2) by inserting after section 9813 the fol-
11 lowing:

12 **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
13 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
14 **AND LYMPH NODE DISSECTIONS FOR THE**
15 **TREATMENT OF BREAST CANCER AND COV-**
16 **ERAGE FOR SECONDARY CONSULTATIONS.**

17 “(a) INPATIENT CARE.—

18 “(1) IN GENERAL.—A group health plan that
19 provides medical and surgical benefits shall ensure
20 that inpatient (and in the case of a lumpectomy,
21 outpatient) coverage and radiation therapy is pro-
22 vided for breast cancer treatment. Such plan may
23 not—

1 “(A) insofar as the attending physician, in
2 consultation with the patient, determines it to
3 be medically necessary—

4 “(i) restrict benefits for any hospital
5 length of stay in connection with a mastec-
6 tomy or breast conserving surgery (such as
7 a lumpectomy) for the treatment of breast
8 cancer to less than 48 hours; or

9 “(ii) restrict benefits for any hospital
10 length of stay in connection with a lymph
11 node dissection for the treatment of breast
12 cancer to less than 24 hours; or

13 “(B) require that a provider obtain author-
14 ization from the plan for prescribing any length
15 of stay required under this paragraph.

16 “(2) EXCEPTION.—Nothing in this section shall
17 be construed as requiring the provision of inpatient
18 coverage if the attending physician, in consultation
19 with the patient, determines that either a shorter pe-
20 riod of hospital stay, or outpatient treatment, is
21 medically appropriate.

22 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
23 In implementing the requirements of this section, a group
24 health plan may not modify the terms and conditions of
25 coverage based on the determination by a participant or

1 beneficiary to request less than the minimum coverage re-
2 quired under subsection (a).

3 “(c) NOTICE.—A group health plan shall provide no-
4 tice to each participant and beneficiary under such plan
5 regarding the coverage required by this section in accord-
6 ance with regulations promulgated by the Secretary. Such
7 notice shall be in writing and prominently positioned in
8 the summary of the plan made available or distributed by
9 the plan and shall be transmitted—

10 “(1) in the next mailing made by the plan to
11 the participant or beneficiary; or

12 “(2) as part of any yearly informational packet
13 sent to the participant or beneficiary;
14 whichever is earlier.

15 “(d) SECONDARY CONSULTATIONS.—

16 “(1) IN GENERAL.—A group health plan that
17 provides coverage with respect to medical and sur-
18 gical services provided in relation to the diagnosis
19 and treatment of cancer shall ensure that coverage
20 is provided for secondary consultations, on terms
21 and conditions that are no more restrictive than
22 those applicable to the initial consultations, by spe-
23 cialists in the appropriate medical fields (including
24 pathology, radiology, and oncology) to confirm or re-
25 fute such diagnosis. Such plan or issuer shall ensure

1 that coverage is provided for such secondary con-
2 sultation whether such consultation is based on a
3 positive or negative initial diagnosis. In any case in
4 which the attending physician certifies in writing
5 that services necessary for such a secondary con-
6 sultation are not sufficiently available from special-
7 ists operating under the plan with respect to whose
8 services coverage is otherwise provided under such
9 plan or by such issuer, such plan or issuer shall en-
10 sure that coverage is provided with respect to the
11 services necessary for the secondary consultation
12 with any other specialist selected by the attending
13 physician for such purpose at no additional cost to
14 the individual beyond that which the individual
15 would have paid if the specialist was participating in
16 the network of the plan.

17 “(2) EXCEPTION.—Nothing in paragraph (1)
18 shall be construed as requiring the provision of sec-
19 ondary consultations where the patient determines
20 not to seek such a consultation.

21 “(e) PROHIBITION ON PENALTIES.—A group health
22 plan may not—

23 “(1) penalize or otherwise reduce or limit the
24 reimbursement of a provider or specialist because

1 the provider or specialist provided care to a partici-
2 pant or beneficiary in accordance with this section;

3 “(2) provide financial or other incentives to a
4 physician or specialist to induce the physician or
5 specialist to keep the length of inpatient stays of pa-
6 tients following a mastectomy, lumpectomy, or a
7 lymph node dissection for the treatment of breast
8 cancer below certain limits or to limit referrals for
9 secondary consultations; or

10 “(3) provide financial or other incentives to a
11 physician or specialist to induce the physician or
12 specialist to refrain from referring a participant or
13 beneficiary for a secondary consultation that would
14 otherwise be covered by the plan involved under sub-
15 section (d).”.

16 (b) EFFECTIVE DATES.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply with respect to plan years be-
19 ginning on or after the date of enactment of this
20 Act.

21 (2) SPECIAL RULE FOR COLLECTIVE BAR-
22 GAINING AGREEMENTS.—In the case of a group
23 health plan maintained pursuant to 1 or more collec-
24 tive bargaining agreements between employee rep-
25 resentatives and 1 or more employers ratified before

1 the date of enactment of this Act, the amendments
 2 made by this section shall not apply to plan years
 3 beginning before the date on which the last collective
 4 bargaining agreements relating to the plan termi-
 5 nates (determined without regard to any extension
 6 thereof agreed to after the date of enactment of this
 7 Act). For purposes of this paragraph, any plan
 8 amendment made pursuant to a collective bargaining
 9 agreement relating to the plan which amends the
 10 plan solely to conform to any requirement added by
 11 this section shall not be treated as a termination of
 12 such collective bargaining agreement.

13 **SEC. 6. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
 14 **THIRD PARTY REVIEWS OF CERTAIN NON-**
 15 **RENEWALS AND DISCONTINUATIONS, IN-**
 16 **CLUDING RESCISSIONS, OF INDIVIDUAL**
 17 **HEALTH INSURANCE COVERAGE.**

18 (a) CLARIFICATION REGARDING APPLICATION OF
 19 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH
 20 INSURANCE COVERAGE.—Section 2742 of the Public
 21 Health Service Act (42 U.S.C. 300gg–42) is amended—

22 (1) in its heading, by inserting “, **CONTINU-**
 23 **ATION IN FORCE, INCLUDING PROHIBITION OF**
 24 **RESCISSION,”** after “**GUARANTEED RENEW-**
 25 **ABILITY”**;

1 “(b) INDEPENDENT DETERMINATION.—If the indi-
2 vidual requests such review by an independent, external
3 third party of a nonrenewal, discontinuation, or rescission
4 of health insurance coverage, the coverage shall remain in
5 effect until such third party determines that the coverage
6 may be nonrenewed, discontinued, or rescinded under sec-
7 tion 2742(b)(2).”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply after the date of the enactment
10 of this Act with respect to health insurance coverage
11 issued before, on, or after such date.

○