

113TH CONGRESS  
1ST SESSION

# H. R. 1531

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.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 12, 2013

Ms. DELAURO (for herself, Mr. BISHOP of Georgia, Ms. BORDALLO, Mr. BRALEY of Iowa, Ms. BROWN of Florida, Mrs. CAPPS, Mr. CARSON of Indiana, Ms. CASTOR of Florida, Ms. CHU, Mr. CLAY, Mr. COHEN, Mr. CONNOLLY, Mr. CONYERS, Mr. COOPER, Ms. DEGETTE, Mr. DINGELL, Ms. EDWARDS, Mr. ELLISON, Mr. ENGEL, Mr. FARR, Ms. FUDGE, Mr. GRIJALVA, Mr. HASTINGS of Florida, Mr. HIGGINS, Mr. HIMES, Mr. HOLT, Mr. ISRAEL, Ms. JACKSON LEE, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSON of Georgia, Ms. KAPTUR, Mr. LANGEVIN, Mr. LARSON of Connecticut, Ms. LEE of California, Mr. LEVIN, Mr. LEWIS, Mr. LOBIONDO, Mr. LOEBSACK, Ms. LOFGREN, Mrs. LOWEY, Mrs. CAROLYN B. MALONEY of New York, Mr. MARKEY, Mr. MCGOVERN, Mr. MCINTYRE, Ms. MOORE, Mr. MORAN, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEAL, Mr. PASTOR of Arizona, Mr. PAYNE, Ms. PINGREE of Maine, Mr. PRICE of North Carolina, Mr. RAHALL, Mr. RANGEL, Ms. ROYBAL-ALLARD, Mr. RUPPERSBERGER, Mr. RUSH, Mr. RYAN of Ohio, Mr. SABLAN, Ms. LINDA T. SÁNCHEZ of California, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Ms. SCHWARTZ, Mr. DAVID SCOTT of Georgia, Mr. SERRANO, Mr. SHERMAN, Ms. SLAUGHTER, Ms. SPEIER, Ms. TSONGAS, Mr. VAN HOLLEN, Ms. WASSERMAN SCHULTZ, Ms. WILSON of Florida, and Mr. YOUNG of Alaska) 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 the Workforce, 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 2013”.

6 **SEC. 2. FINDINGS.**

7       Congress finds the following:

8           (1) According to the National Cancer Institute,  
9       excluding cancers of the skin, breast cancer is the  
10       most frequently diagnosed cancer in women.

11          (2) According to the National Cancer Institute,  
12       an estimated 39,510 women and 410 men died from  
13       breast cancer in 2012.

14          (3) According to the National Cancer Institute,  
15       in 2012 an estimated 226,870 new cases of breast  
16       cancer were diagnosed in women, and an estimated  
17       2,190 breast cancer cases were diagnosed in men.

18          (4) According to the American Cancer Society,  
19       most breast cancer patients undergo some type of  
20       surgical treatment, which may involve lumpectomy

1 or mastectomy with removal of some of the axillary  
2 lymph nodes.

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

5 (6) Health care providers located in a State  
6 serve patients who reside in the State and patients  
7 who reside in other States.

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

13 (8) Research has indicated that treatment for  
14 breast cancer varies according to type of insurance  
15 coverage and State of residence.

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

20 **SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**  
21 **COME SECURITY ACT OF 1974.**

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

1 **“SEC. 716. 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 715 the following:

“Sec. 716. 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 **“SEC. 2729. 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 group or individual  
9 health insurance coverage, that provides medical and  
10 surgical benefits shall ensure that inpatient (and in  
11 the case of a lumpectomy, outpatient) coverage and  
12 radiation therapy is provided for breast cancer treat-  
13 ment. Such plan or coverage may not—

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

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

22 “(ii) restrict benefits for any hospital  
23 length of stay in connection with a lymph  
24 node dissection for the treatment of breast  
25 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 group  
14         or individual health insurance coverage, may not modify  
15         the terms and conditions of coverage based on the deter-  
16         mination by a participant or beneficiary to request less  
17         than the minimum coverage required under subsection (a).

18          “(c) NOTICE.—A group health plan, and a health in-  
19         surance issuer providing group or individual health insur-  
20         ance coverage, shall provide notice to each participant and  
21         beneficiary under such plan or coverage regarding the cov-  
22         erage required by this section in accordance with regula-  
23         tions promulgated by the Secretary. Such notice shall be  
24         in writing and prominently positioned in the summary of

1 the plan or coverage 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 group or individual  
11 health insurance coverage, that provides coverage  
12 with respect to medical and surgical services pro-  
13 vided in relation to the diagnosis and treatment of  
14 cancer shall ensure that coverage is provided for sec-  
15 ondary consultations, on terms and conditions that  
16 are no more restrictive than those applicable to the  
17 initial consultations, by specialists in the appropriate  
18 medical fields (including pathology, radiology, and  
19 oncology) to confirm or refute such diagnosis. Such  
20 plan or issuer shall ensure that coverage is provided  
21 for such secondary consultation whether such con-  
22 sultation is based on a positive or negative initial di-  
23 agnosis. In any case in which the attending physi-  
24 cian certifies in writing that services necessary for  
25 such a secondary consultation are not sufficiently

1 available from specialists operating under the plan  
2 or coverage with respect to whose services coverage  
3 is otherwise provided under such plan or by such  
4 issuer, such plan or issuer shall ensure that coverage  
5 is provided with respect to the services necessary for  
6 the secondary consultation with any other specialist  
7 selected by the attending physician for such purpose  
8 at no additional cost to the individual beyond that  
9 which the individual would have paid if the specialist  
10 was participating in the network of the plan.

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

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

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

23 “(2) provide financial or other incentives to a  
24 physician or specialist to induce the physician or  
25 specialist to keep the length of inpatient stays of pa-

1       tients following a mastectomy, lumpectomy, or a  
2       lymph node dissection for the treatment of breast  
3       cancer below certain limits or to limit referrals for  
4       secondary consultations; or

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

11      (b) EFFECTIVE DATES.—

12              (1) IN GENERAL.—The amendments made by  
13      this section shall apply with respect to plan years be-  
14      ginning on or after 90 days after the date of enact-  
15      ment of this Act.

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

1       thereof agreed to after the date of enactment of this  
 2       Act). For purposes of this paragraph, any plan  
 3       amendment made pursuant to a collective bargaining  
 4       agreement relating to the plan which amends the  
 5       plan solely to conform to any requirement added by  
 6       this section shall not be treated as a termination of  
 7       such collective bargaining agreement.

8       **SEC. 5. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
 9                                   **OF 1986.**

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

12               (1) in the table of sections, by inserting after  
 13       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.”;

14       and

15               (2) by inserting after section 9813 the fol-  
 16       lowing:

17       **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 18                                   **STAY FOR MASTECTOMIES, LUMPECTOMIES,**  
 19                                   **AND LYMPH NODE DISSECTIONS FOR THE**  
 20                                   **TREATMENT OF BREAST CANCER AND COV-**  
 21                                   **ERAGE FOR SECONDARY CONSULTATIONS.**

22       “(a) INPATIENT CARE.—

23               “(1) IN GENERAL.—A group health plan that  
 24       provides medical and surgical benefits shall ensure

1 that inpatient (and in the case of a lumpectomy,  
2 outpatient) coverage and radiation therapy is pro-  
3 vided for breast cancer treatment. Such plan may  
4 not—

5 “(A) insofar as the attending physician, in  
6 consultation with the patient, determines it to  
7 be medically necessary—

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

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

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

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



1 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—

2 In implementing the requirements of this section, a group  
3 health plan may not modify the terms and conditions of  
4 coverage based on the determination by a participant or  
5 beneficiary to request less than the minimum coverage re-  
6 quired under subsection (a).

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

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

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

18 whichever is earlier.

19 “(d) SECONDARY CONSULTATIONS.—

20 “(1) IN GENERAL.—A group health plan that  
21 provides coverage with respect to medical and sur-  
22 gical services provided in relation to the diagnosis  
23 and treatment of cancer shall ensure that coverage  
24 is provided for secondary consultations, on terms  
25 and conditions that are no more restrictive than

1 those applicable to the initial consultations, by spe-  
2 cialists in the appropriate medical fields (including  
3 pathology, radiology, and oncology) to confirm or re-  
4 fute such diagnosis. Such plan or issuer shall ensure  
5 that coverage is provided for such secondary con-  
6 sultation whether such consultation is based on a  
7 positive or negative initial diagnosis. In any case in  
8 which the attending physician certifies in writing  
9 that services necessary for such a secondary con-  
10 sultation are not sufficiently available from special-  
11 ists operating under the plan with respect to whose  
12 services coverage is otherwise provided under such  
13 plan or by such issuer, such plan or issuer shall en-  
14 sure that coverage is provided with respect to the  
15 services necessary for the secondary consultation  
16 with any other specialist selected by the attending  
17 physician for such purpose at no additional cost to  
18 the individual beyond that which the individual  
19 would have paid if the specialist was participating in  
20 the network of the plan.

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

1       “(e) PROHIBITION ON PENALTIES.—A group health  
2 plan may not—

3           “(1) penalize or otherwise reduce or limit the  
4 reimbursement of a provider or specialist because  
5 the provider or specialist provided care to a partici-  
6 pant or beneficiary in accordance with this section;

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

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

20       (b) EFFECTIVE DATES.—

21           (1) IN GENERAL.—The amendments made by  
22 this section shall apply with respect to plan years be-  
23 ginning on or after the date of enactment of this  
24 Act.

1           (2) SPECIAL RULE FOR COLLECTIVE BAR-  
2           GAINING AGREEMENTS.—In the case of a group  
3           health plan maintained pursuant to 1 or more collec-  
4           tive bargaining agreements between employee rep-  
5           resentatives and 1 or more employers ratified before  
6           the date of enactment of this Act, the amendments  
7           made by this section shall not apply to plan years  
8           beginning before the date on which the last collective  
9           bargaining agreements relating to the plan termi-  
10          nates (determined without regard to any extension  
11          thereof agreed to after the date of enactment of this  
12          Act). For purposes of this paragraph, any plan  
13          amendment made pursuant to a collective bargaining  
14          agreement relating to the plan which amends the  
15          plan solely to conform to any requirement added by  
16          this section shall not be treated as a termination of  
17          such collective bargaining agreement.

18 **SEC. 6. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
19                   **THIRD PARTY REVIEWS OF CERTAIN NON-**  
20                   **RENEWALS AND DISCONTINUATIONS, IN-**  
21                   **CLUDING RESCISSIONS, OF INDIVIDUAL**  
22                   **HEALTH INSURANCE COVERAGE.**

23           (a) CLARIFICATION REGARDING APPLICATION OF  
24          GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH

1 INSURANCE COVERAGE.—Section 2742 of the Public  
2 Health Service Act (42 U.S.C. 300gg–42) is amended—

3 (1) in its heading, by inserting “**AND CON-**  
4 **TINUATION IN FORCE, INCLUDING PROHIBI-**  
5 **TION OF RESCISSION,”** after “**GUARANTEED RE-**  
6 **NEWABILITY”**;

7 (2) in subsection (a), by inserting “, including  
8 without rescission,” after “continue in force”; and

9 (3) in subsection (b)(2), by inserting before the  
10 period at the end the following: “, including inten-  
11 tional concealment of material facts regarding a  
12 health condition related to the condition for which  
13 coverage is being claimed”.

14 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL  
15 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1  
16 of part B of title XXVII of the Public Health Service Act  
17 is amended by adding at the end the following new section:

18 “**SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**

19 **THIRD PARTY REVIEW IN CERTAIN CASES.**

20 “(a) NOTICE AND REVIEW RIGHT.—If a health in-  
21 surance issuer determines to nonrenew or not continue in  
22 force, including rescind, health insurance coverage for an  
23 individual in the individual market on the basis described  
24 in section 2742(b)(2) before such nonrenewal, discontinu-  
25 ation, or rescission, may take effect the issuer shall pro-

1 vide the individual with notice of such proposed non-  
2 renewal, discontinuation, or rescission and an opportunity  
3 for a review of such determination by an independent, ex-  
4 ternal third party under procedures specified by the Sec-  
5 retary.

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

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

○