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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.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Breast Cancer Patient Protection Act of 2013''.

**SEC. 2. FINDINGS.**

Congress finds the following:

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

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

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

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

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

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

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

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

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

(9) Breast cancer patients have reported adverse outcomes, including infection and inadequately controlled pain, resulting from premature hospital discharge following breast cancer surgery.

**SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end 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.**

''(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) insofar as the attending physician, in consultation with the patient, determines it to be medically necessary—

''(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 this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines 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 the

summary of the plan 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.

''(d) SECONDARY CONSULTATIONS.—

''(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 coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is 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 con-

sultation 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.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) 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—

''(1) 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;

''(2) 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; or

''(3) 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 subsection (d).''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating 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.''.

(c) EFFECTIVE DATES.—

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

(2) 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 rep-

resentatives 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.

**SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.**

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2728 of such Act (42 U.S.C. 300gg–28), as redesignated by section 1001(2) of the Patient Protection and Affordable Care Act (Public Law 111–148), the following:

**"SEC. 2729. 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 group or individual health insurance coverage, 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) insofar as the attending physician, in consultation with the patient, determines it to be medically necessary—

''(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 this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines 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 group or individual health insurance coverage, 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 group or individual health insurance coverage, shall provide notice to each participant and beneficiary under such plan or coverage 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 the summary of

the plan or coverage 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.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing group or individual health insurance coverage, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is 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 or coverage 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.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing group or individual health insurance coverage, may not—

''(1) 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;

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

tients 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; or

''(3) 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 subsection (d).''.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after 90 days after the date of enactment of this Act.

(2) 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.

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

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

(1) in the table of sections, by inserting after 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.";

and

(2) by inserting after 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.**

"(a) INPATIENT CARE.—

"(1) IN GENERAL.—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 may not—

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

''(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 for prescribing any length of stay required under this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines 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 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 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 the summary of the plan made available or distributed by the plan and shall be transmitted—

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

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

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—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 coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than

those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is 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.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) 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;

''(2) 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; or

''(3) 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 involved under subsection (d).''.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

(2) 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.

**SEC. 6. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEWS OF CERTAIN NON-RENEWALS AND DISCONTINUATIONS, INCLUDING RESCISSIONS, OF INDIVIDUAL HEALTH INSURANCE COVERAGE.**

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

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

(1) in its heading, by inserting ''**AND CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**'' after ''**GUARANTEED RENEWABILITY**'';

(2) in subsection (a), by inserting '', including without rescission,'' after ''continue in force''; and

(3) in subsection (b)(2), by inserting before the period at the end the following: '', including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed''.

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

**''SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.**

''(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall pro-

vide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

''(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).''.

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

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