

108TH CONGRESS
1ST SESSION

H. R. 1319

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage for second opinions.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 2003

Mrs. DAVIS of California introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, 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 amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage for second opinions.

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 “Second Opinion Cov-
5 erage Act of 2003”.

1 **SEC. 2. COVERAGE OF SECOND OPINIONS.**

2 (a) GROUP HEALTH PLANS.—

3 (1) PUBLIC HEALTH SERVICE ACT AMEND-
4 MENTS.—(A) Subpart 2 of part A of title XXVII of
5 the Public Health Service Act is amended by adding
6 at the end the following new section:

7 **“SEC. 2707. COVERAGE OF SECOND OPINIONS.**

8 “(a) IN GENERAL.—A group health plan, and a
9 health insurance issuer offering group health insurance
10 coverage, shall provide that when requested by a partici-
11 pant, beneficiary, or enrollee or participating health care
12 professional who is treating the participant, beneficiary,
13 or enrollee, the plan or issuer shall provide or authorize
14 a second opinion by an appropriately qualified health care
15 professional. Reasons for a second opinion to be provided
16 or authorized include the following:

17 “(1) If the participant, beneficiary, or enrollee
18 questions the reasonableness or necessity of rec-
19 ommended surgical procedures.

20 “(2) If the participant, beneficiary, or enrollee
21 questions a diagnosis or plan of care for a condition
22 that threatens loss of life, loss of limb, loss of bodily
23 function, or substantial impairment, including a seri-
24 ous chronic condition.

25 “(3) If the clinical indications are not clear or
26 are complex and confusing, a diagnosis is in doubt

1 due to conflicting test results, or the treating health
2 care professional is unable to diagnose the condition,
3 and the participant, beneficiary, or enrollee requests
4 an additional diagnosis.

5 “(4) If the treatment plan in progress is not
6 improving the medical condition of the participant,
7 beneficiary, or enrollee within an appropriate period
8 of time given the diagnosis and plan of care and the
9 participant, beneficiary, or enrollee requests a sec-
10 ond opinion regarding the diagnosis or continuance
11 of the treatment.

12 “(5) If the participant, beneficiary, or enrollee
13 has attempted to follow the plan of care or consulted
14 with the initial provider concerning serious concerns
15 about the diagnosis or plan of care.

16 “(b) APPROPRIATELY QUALIFIED HEALTH CARE
17 PROFESSIONAL DEFINED.—For purposes of this section,
18 an ‘appropriately qualified health care professional’ is a
19 primary care physician or a specialist who is acting within
20 the professional’s scope of practice and who possesses a
21 clinical background, including training and expertise, re-
22 lated to the particular illness, disease, condition or condi-
23 tions associated with the request for a second opinion.

24 “(c) TIMELY RENDERING OF OPINIONS.—If a partic-
25 ipant, beneficiary, or enrollee or participating health care

1 professional who is treating a participant, beneficiary, or
2 enrollee requests a second opinion pursuant to this section,
3 an authorization or denial shall be provided in an expedi-
4 tious manner. When the condition of the participant, bene-
5 ficiary, or enrollee is such that the individual faces an im-
6 minent and serious threat to health, including the poten-
7 tial loss of life, limb, or other major bodily function, or
8 lack of timeliness that would be detrimental to the individ-
9 ual's ability to regarding maximum function, the second
10 opinion shall be rendered in a timely fashion appropriate
11 for the nature of the condition involved, but not to exceed
12 72 hours after the time of the plan's receipt of the request,
13 whenever possible. Each plan or issuer shall file with the
14 Secretary timelines for responding to requests for second
15 opinions for cases involving emergency needs, urgent care,
16 and other requests by not later than 90 days after the
17 date of the enactment of this section, and within 30 days
18 of any amendment to the timelines. The timelines shall
19 be made available to the public upon request.

20 “(d) LIMITATION ON LIABILITY FOR COSTS.—If a
21 group health plan, or health insurance issuer offering a
22 group health insurance in connection with such a plan,
23 approves a request by a participant, beneficiary, or en-
24 rollee for a second opinion, the participant, beneficiary,
25 or enrollee shall be responsible only for the costs of appli-

1 cable copayments that the group health plan or issuer re-
2 quires for similar referrals.

3 “(e) PRIMARY CARE REQUESTS.—If the participant,
4 beneficiary, or enrollee is requesting a second opinion
5 about care from the individual’s primary care physician,
6 the second opinion shall be provided by an appropriately
7 qualified health care professional of the individual’s choice
8 within the same physician organization.

9 “(f) SPECIALISTS.—If the participant, beneficiary, or
10 enrollee is requesting a second opinion about care from
11 a specialist, the second opinion shall be provided by any
12 provider of that individual’s choice from any independent
13 practice association or medical group within the network
14 of the same or equivalent specialty. If the specialist is not
15 within the same physician organization, the plan or issuer
16 shall incur the cost or negotiate the fee arrangements of
17 that second opinion, beyond the applicable copayments
18 which shall be paid by the participant, beneficiary, or en-
19 rollee. If not authorized by the plan or issuer, additional
20 medical opinions not within the original physician organi-
21 zation shall be the responsibility of the enrollee.

22 “(g) USE OF OUTSIDE PLAN CONSULTANTS.—If
23 there is no participating provider under the plan or cov-
24 erage within the network who meets the standard specified
25 in subsection (b), then the plan or issuer shall authorize

1 a second opinion by an appropriately qualified health pro-
2 fessional outside of the plan’s or issuer’s provider network.
3 In approving a second opinion either inside or outside of
4 the plan’s or issuer’s provider network, the plan or issuer
5 shall take into account the ability of the participant, bene-
6 ficiary, or enrollee to travel to the provider, but the plan
7 or issuer is not liable for costs relating to such travel.

8 “(h) CONSULTATION REPORTS.—The plan or issuer
9 shall require the second opinion health professional to pro-
10 vide the participant, beneficiary, or enrollee and the initial
11 health professional with a consultation report, including
12 any recommended procedures or test that the second opin-
13 ion health professional believes appropriate. Nothing in
14 this section shall be construed to prevent the plan or issuer
15 from authorizing, based on its independent determination,
16 additional medical opinions concerning the medical condi-
17 tion of a participant, beneficiary, or enrollee.

18 “(i) NOTICE.—If the plan or issuer denies a request
19 by a participant, beneficiary, or enrollee for a second opin-
20 ion, it shall notify the participant, beneficiary, or enrollee
21 in writing of the reasons for the denial and shall inform
22 the participant, beneficiary, or enrollee of the rights to file
23 a grievance with the plan.

24 “(j) LIMITATION TO PARTICIPATING PROVIDERS.—
25 Unless authorized by the plan or issuer, in order for serv-

1 ices to be covered the participant, beneficiary, or enrollee
 2 shall obtain services only from a provider who is partici-
 3 pating in, or under contract with, the plan or issuer pursu-
 4 ant to the specific contract under which the participant,
 5 beneficiary, or enrollee is entitled to health care services.
 6 The plan or issuer may limit referrals to its network of
 7 providers if there is a participating plan provider who
 8 meets the standard specified in subsection (b).

9 “(k) EXEMPTION.—This section shall not apply to
 10 health care service plan contracts that provide benefits to
 11 enrollees through preferred provider contracting arrange-
 12 ments if, subject to all other terms and conditions of the
 13 contract that apply generally to all other benefits, access
 14 to and coverage for second opinions are not limited.

15 “(l) NOTICE.—A group health plan under this part
 16 shall comply with the notice requirement under section
 17 714(b) of the Employee Retirement Income Security Act
 18 of 1974 with respect to the requirements of this section
 19 as if such section applied to such plan.”.

20 (B) Section 2723(c) of such Act (42 U.S.C.
 21 300gg–23(c)) is amended by striking “section 2704”
 22 and inserting “sections 2704 and 2707”.

23 (2) ERISA AMENDMENTS.—(A) Subpart B of
 24 part 7 of subtitle B of title I of the Employee Re-

1 retirement Income Security Act of 1974 is amended by
2 adding at the end the following new section:

3 **“SEC. 714. COVERAGE OF SECOND OPINIONS.**

4 “(a) REQUIREMENT.—The provisions of section 2707
5 shall apply under this subtitle to group health plans, and
6 to group health insurance coverage offered by a health in-
7 surance issuer, in the same manner as they apply if such
8 provisions were included in this subsection.

9 “(b) NOTICE UNDER GROUP HEALTH PLAN.—The
10 imposition of the requirement of this section shall be treat-
11 ed as a material modification in the terms of the plan de-
12 scribed in section 102(a)(1), for purposes of assuring no-
13 tice of such requirements under the plan; except that the
14 summary description required to be provided under the
15 last sentence of section 104(b)(1) with respect to such
16 modification shall be provided by not later than 60 days
17 after the first day of the first plan year in which such
18 requirement apply.”.

19 (B) Section 731(c) of such Act (29 U.S.C.
20 1191(c)) is amended by striking “section 711” and
21 inserting “sections 711 and 714”.

22 (C) Section 732(a) of such Act (29 U.S.C.
23 1191a(a)) is amended by striking “section 711” and
24 inserting “sections 711 and 714”.

1 (D) The table of contents in section 1 of such
 2 Act is amended by inserting after the item relating
 3 to section 713 the following new item:

“Sec. 714. Coverage of second opinions.”.

4 (3) INTERNAL REVENUE CODE AMEND-
 5 MENTS.—

6 (A) IN GENERAL.—Subchapter B of chap-
 7 ter 100 of the Internal Revenue Code of 1986
 8 is amended—

9 (i) in the table of sections, by insert-
 10 ing after the item relating to section 9812
 11 the following new item:

“Sec. 9813. Coverage of second opinions.”; and

12 (ii) by inserting after section 9812 the
 13 following:

14 **“SEC. 9813. COVERAGE OF SECOND OPINIONS.**

15 “The requirements of section 2707 of the Public
 16 Health Service Act shall apply under this section as if such
 17 section were included herein.”.

18 (B) CONFORMING AMENDMENT.—Section
 19 4980D(d)(1) of such Code is amended by strik-
 20 ing “section 9811” and inserting “sections
 21 9811 and 9813”.

22 (b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B
 23 of title XXVII of the Public Health Service Act is amend-

1 ed by inserting after section 2752 the following new sec-
 2 tion:

3 **“SEC. 2753. COVERAGE OF SECOND OPINIONS.**

4 “(a) IN GENERAL.—The provisions of section 2707
 5 (other than subsection (l)) shall apply to health insurance
 6 coverage offered by a health insurance issuer in the indi-
 7 vidual market in the same manner as they apply to health
 8 insurance coverage offered by a health insurance issuer
 9 in connection with a group health plan in the small or
 10 large group market.

11 “(b) NOTICE.—A health insurance issuer under this
 12 part shall comply with the notice requirement under sec-
 13 tion 714(b) of the Employee Retirement Income Security
 14 Act of 1974 with respect to the requirements referred to
 15 in subsection (a) as if such section applied to such issuer
 16 and such issuer were a group health plan.”.

17 (2) Section 2762(b)(2) of such Act (42 U.S.C.
 18 300gg–62(b)(2)) is amended by striking “section 2751”
 19 and inserting “sections 2751 and 2753”.

20 (c) EFFECTIVE DATES.—

21 (1) GROUP HEALTH PLANS AND GROUP
 22 HEALTH INSURANCE COVERAGE.—Subject to para-
 23 graph (3), the amendments made by subsection (a)
 24 apply with respect to group health plans for plan
 25 years beginning on or after January 1, 2004.

1 (2) INDIVIDUAL HEALTH INSURANCE COV-
2 ERAGE.—The amendments made by subsection (b)
3 apply with respect to health insurance coverage of-
4 fered, sold, issued, renewed, in effect, or operated in
5 the individual market on or after such date.

6 (3) COLLECTIVE BARGAINING EXCEPTION.—In
7 the case of a group health plan maintained pursuant
8 to 1 or more collective bargaining agreements be-
9 tween employee representatives and 1 or more em-
10 ployers ratified before the date of enactment of this
11 Act, the amendments made subsection (a) shall not
12 apply to plan years beginning before the later of—

13 (A) the date on which the last collective
14 bargaining agreements relating to the plan ter-
15 minates (determined without regard to any ex-
16 tension thereof agreed to after the date of en-
17 actment of this Act), or

18 (B) January 1, 2004.

19 For purposes of subparagraph (A), any plan amend-
20 ment made pursuant to a collective bargaining
21 agreement relating to the plan which amends the
22 plan solely to conform to any requirement added by
23 subsection (a) shall not be treated as a termination
24 of such collective bargaining agreement.

1 (d) COORDINATION OF ADMINISTRATION.—The Sec-
2 retary of Labor, the Secretary of the Treasury, and the
3 Secretary of Health and Human Services shall ensure,
4 through the execution of an interagency memorandum of
5 understanding among such Secretaries, that—

6 (1) regulations, rulings, and interpretations
7 issued by such Secretaries relating to the same mat-
8 ter over which two or more such Secretaries have re-
9 sponsibility under the provisions of this Act (and the
10 amendments made thereby) are administered so as
11 to have the same effect at all times; and

12 (2) coordination of policies relating to enforcing
13 the same requirements through such Secretaries in
14 order to have a coordinated enforcement strategy
15 that avoids duplication of enforcement efforts and
16 assigns priorities in enforcement.

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