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109TH CONGRESS
1ST SESSION

H. R. 2936

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

JUNE 16, 2005

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

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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.

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 ''Second Opinion Coverage Act of 2005''.

SEC. 2. COVERAGE OF SECOND OPINIONS.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—(A) Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. COVERAGE OF SECOND OPINIONS.

''(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide that when requested by a participant, beneficiary, or enrollee or participating health care professional who is treating the participant, beneficiary, or enrollee, the plan or issuer shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized include the following:

''(1) If the participant, beneficiary, or enrollee questions the reasonableness or necessity of recommended surgical procedures.

''(2) If the participant, beneficiary, or enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including a serious chronic condition.

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

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

''(4) If the treatment plan in progress is not improving the medical condition of the participant, beneficiary, or enrollee within an appropriate period of time given the diagnosis and plan of care and the participant, beneficiary, or enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

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

''(b) APPROPRIATELY QUALIFIED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this section, an 'appropriately qualified health care professional' is a primary care physician or a specialist who is acting within the professional's scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

''(c) TIMELY RENDERING OF OPINIONS.—If a participant, beneficiary, or enrollee or participating health care

professional who is treating a participant, beneficiary, or enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the condition of the participant, beneficiary, or enrollee is such that the individual faces an imminent and serious threat to health, including the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the individual's ability to regarding maximum function, the second opinion shall be rendered in a timely fashion appropriate for the nature of the condition involved, but not to exceed 72 hours after the time of the plan's receipt of the request, whenever possible. Each plan or issuer shall file with the Secretary timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by not later than 90 days after the date of the enactment of this section, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

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

cable copayments that the group health plan or issuer requires for similar referrals.

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

''(f) SPECIALISTS.—If the participant, beneficiary, or enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of that individual's choice from any independent practice association or medical group within the network of the same or equivalent specialty. If the specialist is not within the same physician organization, the plan or issuer shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments which shall be paid by the participant, beneficiary, or enrollee. If not authorized by the plan or issuer, additional medical opinions not within the original physician organization shall be the responsibility of the enrollee.

''(g) USE OF OUTSIDE PLAN CONSULTANTS.—If there is no participating provider under the plan or coverage within the network who meets the standard specified in subsection (b), then the plan or issuer shall authorize

a second opinion by an appropriately qualified health professional outside of the plan's or issuer's provider network. In approving a second opinion either inside or outside of the plan's or issuer's provider network, the plan or issuer shall take into account the ability of the participant, beneficiary, or enrollee to travel to the provider, but the plan or issuer is not liable for costs relating to such travel.

''(h) CONSULTATION REPORTS.—The plan or issuer shall require the second opinion health professional to provide the participant, beneficiary, or enrollee and the initial health professional with a consultation report, including any recommended procedures or test that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the plan or issuer from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of a participant, beneficiary, or enrollee.

''(i) NOTICE.—If the plan or issuer denies a request by a participant, beneficiary, or enrollee for a second opinion, it shall notify the participant, beneficiary, or enrollee in writing of the reasons for the denial and shall inform the participant, beneficiary, or enrollee of the rights to file a grievance with the plan.

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

ices to be covered the participant, beneficiary, or enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan or issuer pursuant to the specific contract under which the participant, beneficiary, or enrollee is entitled to health care services. The plan or issuer may limit referrals to its network of providers if there is a participating plan provider who meets the standard specified in subsection (b).

''(k) EXEMPTION.—This section shall not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions are not limited.

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

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

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

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

"SEC. 714. COVERAGE OF SECOND OPINIONS.

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

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirement of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirement apply.''.

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

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

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

''714. Coverage of second opinions.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—

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

(i) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''9813. Coverage of second opinions.'';

and

(ii) by inserting after section 9812 the following:

''SEC. 9813. COVERAGE OF SECOND OPINIONS.

''The requirements of section 2707 of the Public Health Service Act shall apply under this section as if such section were included herein.''.

(B) CONFORMING AMENDMENT.—Section 4980D(d)(1) of such Code is amended by striking ''section 9811'' and inserting ''sections 9811 and 9813''.

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

ed by inserting after section 2752 the following new section:

''SEC. 2753. COVERAGE OF SECOND OPINIONS.

''(a) IN GENERAL.—The provisions of section 2707 (other than subsection (l)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 714(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

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

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—Subject to paragraph (3), the amendments made by subsection (a) apply with respect to group health plans for plan years beginning on or after January 1, 2006.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by subsection (b) apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(3) COLLECTIVE BARGAINING EXCEPTION.—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 subsection (a) shall not apply to plan years beginning before the later of—

(A) 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), or

(B) January 1, 2006.

For purposes of subparagraph (A), 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 subsection (a) shall not be treated as a termination of such collective bargaining agreement.

(d) COORDINATION OF ADMINISTRATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

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