110TH CONGRESS
2D SESSION

H. R. 758

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 25 (legislative day, SEPTEMBER 17), 2008
Received

AN ACT

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 2008''.

SEC. 2. FINDINGS.

Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States;

(3) 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 1 State as well as health plans operating among the several States;

(4) currently, 20 States mandate minimum hospital stay coverage after a patient undergoes a mastectomy;

(5) according to the American Cancer Society, there were 40,954 deaths due to breast cancer in women in 2004;

(6) according to the American Cancer Society, there are currently over 2.0 million women living in the United States who have been treated for breast cancer; and

(7) according to the American Cancer Society, a woman in the United States has a 1 in 8 chance of developing invasive breast cancer in her lifetime.

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. 714. 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 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 sec-

ondary 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 713 the following:

"Sec. 714. 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 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. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

"SEC. 2707. 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 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 OR INCENTIVES.—A group health plan, and a health insurance issuer pro-

viding 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) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to group health plans for 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. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

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

''SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

''The provisions of section 2707 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) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

SEC. 6. 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 9812 the following:

''Sec. 9813. 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 9812 the following:

"SEC. 9813. 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 en-

sure 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. 7. 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 "**, 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 provide 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.

Passed the House of Representatives September 25, 2008.

Attest: LORRAINE C. MILLER,

Clerk.