

110TH CONGRESS  
2D SESSION

# H. R. 758

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IN THE SENATE OF THE UNITED STATES

SEPTEMBER 25 (legislative day, SEPTEMBER 17), 2008

Received

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## 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.

1       *Be it enacted by the Senate and House of Representa-*  
2   *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2       This Act may be cited as the “Breast Cancer Patient  
3 Protection Act of 2008”.

4 **SEC. 2. FINDINGS.**

5       Congress finds that—

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

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

11           (3) in order to provide for uniform treatment of  
12 health care providers and patients among the States,  
13 it is necessary to cover health plans operating in 1  
14 State as well as health plans operating among the  
15 several States;

16           (4) currently, 20 States mandate minimum hos-  
17 pital stay coverage after a patient undergoes a mas-  
18 tectomy;

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

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

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

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

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

10 **“SEC. 714. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
11 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**  
12 **AND LYMPH NODE DISSECTIONS FOR THE**  
13 **TREATMENT OF BREAST CANCER AND COV-**  
14 **ERAGE FOR SECONDARY CONSULTATIONS.**

15 “(a) INPATIENT CARE.—

16 “(1) IN GENERAL.—A group health plan, and a  
17 health insurance issuer providing health insurance  
18 coverage in connection with a group health plan,  
19 that provides medical and surgical benefits shall en-  
20 sure that inpatient (and in the case of a  
21 lumpectomy, outpatient) coverage and radiation  
22 therapy is provided for breast cancer treatment.  
23 Such plan or coverage may not—

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

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

9 “(ii) restrict benefits for any hospital  
10 length of stay in connection with a lymph  
11 node dissection for the treatment of breast  
12 cancer to less than 24 hours; or

13 “(B) require that a provider obtain author-  
14 ization from the plan or the issuer for pre-  
15 scribing any length of stay required under this  
16 paragraph.

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

23 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—  
24 In implementing the requirements of this section, a group  
25 health plan, and a health insurance issuer providing health

1 insurance coverage in connection with a group health plan,  
2 may not modify the terms and conditions of coverage  
3 based on the determination by a participant or beneficiary  
4 to request less than the minimum coverage required under  
5 subsection (a).

6 “(c) NOTICE.—A group health plan, and a health in-  
7 surance issuer providing health insurance coverage in con-  
8 nection with a group health plan shall provide notice to  
9 each participant and beneficiary under such plan regard-  
10 ing the coverage required by this section in accordance  
11 with regulations promulgated by the Secretary. Such no-  
12 tice shall be in writing and prominently positioned in the  
13 summary of the plan made available or distributed by the  
14 plan or issuer and shall be transmitted—

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

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

19 whichever is earlier.

20 “(d) SECONDARY CONSULTATIONS.—

21 “(1) IN GENERAL.—A group health plan, and a  
22 health insurance issuer providing health insurance  
23 coverage in connection with a group health plan,  
24 that provides coverage with respect to medical and  
25 surgical services provided in relation to the diagnosis

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

24 “(2) EXCEPTION.—Nothing in paragraph (1)  
25 shall be construed as requiring the provision of sec-

1       ondary consultations where the patient determines  
2       not to seek such a consultation.

3       “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—

4   A group health plan, and a health insurance issuer pro-  
5   viding health insurance coverage in connection with a  
6   group health plan, may not—

7           “(1) penalize or otherwise reduce or limit the  
8       reimbursement of a provider or specialist because  
9       the provider or specialist provided care to a partici-  
10      pant or beneficiary in accordance with this section;

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

18           “(3) provide financial or other incentives to a  
19      physician or specialist to induce the physician or  
20      specialist to refrain from referring a participant or  
21      beneficiary for a secondary consultation that would  
22      otherwise be covered by the plan or coverage in-  
23      volved under subsection (d).”.

24       (b) CLERICAL AMENDMENT.—The table of contents  
25   in section 1 of the Employee Retirement Income Security

1 Act of 1974 is amended by inserting after the item relat-  
2 ing 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.”.

3 (c) EFFECTIVE DATES.—

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

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



1 **SEC. 4. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**  
 2 **ACT RELATING TO THE GROUP MARKET.**

3 (a) IN GENERAL.—Subpart 2 of part A of title  
 4 XXVII of the Public Health Service Act (42 U.S.C.  
 5 300gg–4 et seq.) is amended by adding at the end the  
 6 following:

7 **“SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 8 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**  
 9 **AND LYMPH NODE DISSECTIONS FOR THE**  
 10 **TREATMENT OF BREAST CANCER AND COV-**  
 11 **ERAGE FOR SECONDARY CONSULTATIONS.**

12 “(a) INPATIENT CARE.—

13 “(1) IN GENERAL.—A group health plan, and a  
 14 health insurance issuer providing health insurance  
 15 coverage in connection with a group health plan,  
 16 that provides medical and surgical benefits shall en-  
 17 sure that inpatient (and in the case of a  
 18 lumpectomy, outpatient) coverage and radiation  
 19 therapy is provided for breast cancer treatment.  
 20 Such plan or coverage may not—

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

24 “(i) restrict benefits for any hospital  
 25 length of stay in connection with a mastec-  
 26 tomy or breast conserving surgery (such as

1 a lumpectomy) for the treatment of breast  
2 cancer to less than 48 hours; or

3 “(ii) restrict benefits for any hospital  
4 length of stay in connection with a lymph  
5 node dissection for the treatment of breast  
6 cancer to less than 24 hours; or

7 “(B) require that a provider obtain author-  
8 ization from the plan or the issuer for pre-  
9 scribing any length of stay required under this  
10 paragraph.

11 “(2) EXCEPTION.—Nothing in this section shall  
12 be construed as requiring the provision of inpatient  
13 coverage if the attending physician, in consultation  
14 with the patient, determines that either a shorter pe-  
15 riod of hospital stay, or outpatient treatment, is  
16 medically appropriate.

17 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—  
18 In implementing the requirements of this section, a group  
19 health plan, and a health insurance issuer providing health  
20 insurance coverage in connection with a group health plan,  
21 may not modify the terms and conditions of coverage  
22 based on the determination by a participant or beneficiary  
23 to request less than the minimum coverage required under  
24 subsection (a).

1       “(c) NOTICE.—A group health plan, and a health in-  
2       surance issuer providing health insurance coverage in con-  
3       nection with a group health plan shall provide notice to  
4       each participant and beneficiary under such plan regard-  
5       ing the coverage required by this section in accordance  
6       with regulations promulgated by the Secretary. Such no-  
7       tice shall be in writing and prominently positioned in the  
8       summary of the plan made available or distributed by the  
9       plan or issuer and shall be transmitted—

10               “(1) in the next mailing made by the plan or  
11       issuer to the participant or beneficiary; or

12               “(2) as part of any yearly informational packet  
13       sent to the participant or beneficiary;  
14       whichever is earlier.

15       “(d) SECONDARY CONSULTATIONS.—

16               “(1) IN GENERAL.—A group health plan, and a  
17       health insurance issuer providing health insurance  
18       coverage in connection with a group health plan,  
19       that provides coverage with respect to medical and  
20       surgical services provided in relation to the diagnosis  
21       and treatment of cancer shall ensure that coverage  
22       is provided for secondary consultations, on terms  
23       and conditions that are no more restrictive than  
24       those applicable to the initial consultations, by spe-  
25       cialists in the appropriate medical fields (including

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

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

23 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—  
24 A group health plan, and a health insurance issuer pro-

1 viding health insurance coverage in connection with a  
2 group health 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 or coverage in-  
19 volved under subsection (d).”.

20 (b) EFFECTIVE DATES.—

21 (1) IN GENERAL.—The amendments made by  
22 this section shall apply to group health plans for  
23 plan years beginning on or after 90 days after the  
24 date of enactment of this 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. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT**  
19 **RELATING TO THE INDIVIDUAL MARKET.**

20          (a) IN GENERAL.—Subpart 2 of part B of title  
21 XXVII of the Public Health Service Act (42 U.S.C.  
22 300gg–51 et seq.) is amended by adding at the end the  
23 following new section:

1 **“SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 2 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**  
 3 **AND LYMPH NODE DISSECTIONS FOR THE**  
 4 **TREATMENT OF BREAST CANCER AND SEC-**  
 5 **ONDARY CONSULTATIONS.**

6 “The provisions of section 2707 shall apply to health  
 7 insurance coverage offered by a health insurance issuer  
 8 in the individual market in the same manner as they apply  
 9 to health insurance coverage offered by a health insurance  
 10 issuer in connection with a group health plan in the small  
 11 or large group market.”.

12 (b) **EFFECTIVE DATE.**—The amendment made by  
 13 this section shall apply with respect to health insurance  
 14 coverage offered, sold, issued, renewed, in effect, or oper-  
 15 ated in the individual market on or after the date of enact-  
 16 ment of this Act.

17 **SEC. 6. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
 18 **OF 1986.**

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

21 (1) in the table of sections, by inserting after  
 22 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.”;

23 and

1           (2) by inserting after section 9812 the fol-  
2       lowing:

3       **“SEC. 9813. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
4               **STAY FOR MASTECTOMIES, LUMPECTOMIES,**  
5               **AND LYMPH NODE DISSECTIONS FOR THE**  
6               **TREATMENT OF BREAST CANCER AND COV-**  
7               **ERAGE FOR SECONDARY CONSULTATIONS.**

8       “(a) INPATIENT CARE.—

9           “(1) IN GENERAL.—A group health plan that  
10       provides medical and surgical benefits shall ensure  
11       that inpatient (and in the case of a lumpectomy,  
12       outpatient) coverage and radiation therapy is pro-  
13       vided for breast cancer treatment. Such plan may  
14       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



1 node dissection for the treatment of breast  
2 cancer to less than 24 hours; or

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

6 “(2) EXCEPTION.—Nothing in this section shall  
7 be construed as requiring the provision of inpatient  
8 coverage if the attending physician, in consultation  
9 with the patient, determines that either a shorter pe-  
10 riod of hospital stay, or outpatient treatment, is  
11 medically appropriate.

12 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—  
13 In implementing the requirements of this section, a group  
14 health plan may not modify the terms and conditions of  
15 coverage based on the determination by a participant or  
16 beneficiary to request less than the minimum coverage re-  
17 quired under subsection (a).

18 “(c) NOTICE.—A group health plan shall provide no-  
19 tice to each participant and beneficiary under such plan  
20 regarding the coverage required by this section in accord-  
21 ance with regulations promulgated by the Secretary. Such  
22 notice shall be in writing and prominently positioned in  
23 the summary of the plan made available or distributed by  
24 the plan and shall be transmitted—

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

3           “(2) as part of any yearly informational packet  
4           sent to the participant or beneficiary;  
5           whichever is earlier.

6           “(d) SECONDARY CONSULTATIONS.—

7           “(1) IN GENERAL.—A group health plan that  
8           provides coverage with respect to medical and sur-  
9           gical services provided in relation to the diagnosis  
10          and treatment of cancer shall ensure that coverage  
11          is provided for secondary consultations, on terms  
12          and conditions that are no more restrictive than  
13          those applicable to the initial consultations, by spe-  
14          cialists in the appropriate medical fields (including  
15          pathology, radiology, and oncology) to confirm or re-  
16          fute such diagnosis. Such plan or issuer shall ensure  
17          that coverage is provided for such secondary con-  
18          sultation whether such consultation is based on a  
19          positive or negative initial diagnosis. In any case in  
20          which the attending physician certifies in writing  
21          that services necessary for such a secondary con-  
22          sultation are not sufficiently available from special-  
23          ists operating under the plan with respect to whose  
24          services coverage is otherwise provided under such  
25          plan or by such issuer, such plan or issuer shall en-

1       sure that coverage is provided with respect to the  
2       services necessary for the secondary consultation  
3       with any other specialist selected by the attending  
4       physician for such purpose at no additional cost to  
5       the individual beyond that which the individual  
6       would have paid if the specialist was participating in  
7       the network of the plan.

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

12      “(e) PROHIBITION ON PENALTIES.—A group health  
13      plan may not—

14              “(1) penalize or otherwise reduce or limit the  
15      reimbursement of a provider or specialist because  
16      the provider or specialist provided care to a partici-  
17      pant or beneficiary in accordance with this section;

18              “(2) provide financial or other incentives to a  
19      physician or specialist to induce the physician or  
20      specialist to keep the length of inpatient stays of pa-  
21      tients following a mastectomy, lumpectomy, or a  
22      lymph node dissection for the treatment of breast  
23      cancer below certain limits or to limit referrals for  
24      secondary consultations; or

1           “(3) provide financial or other incentives to a  
2     physician or specialist to induce the physician or  
3     specialist to refrain from referring a participant or  
4     beneficiary for a secondary consultation that would  
5     otherwise be covered by the plan involved under sub-  
6     section (d).”.

7     (b) EFFECTIVE DATES.—

8           (1) IN GENERAL.—The amendments made by  
9     this section shall apply with respect to plan years be-  
10    ginning on or after the date of enactment of this  
11    Act.

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

1 plan solely to conform to any requirement added by  
 2 this section shall not be treated as a termination of  
 3 such collective bargaining agreement.

4 **SEC. 7. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
 5 **THIRD PARTY REVIEWS OF CERTAIN NON-**  
 6 **RENEWALS AND DISCONTINUATIONS, IN-**  
 7 **CLUDING RESCISSIONS, OF INDIVIDUAL**  
 8 **HEALTH INSURANCE COVERAGE.**

9 (a) CLARIFICATION REGARDING APPLICATION OF  
 10 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH  
 11 INSURANCE COVERAGE.—Section 2742 of the Public  
 12 Health Service Act (42 U.S.C. 300gg–42) is amended—

13 (1) in its heading, by inserting “, **CONTINU-**  
 14 **ATION IN FORCE, INCLUDING PROHIBITION OF**  
 15 **RESCISSION,”** after “**GUARANTEED RENEW-**  
 16 **ABILITY”**;

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

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

24 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL  
 25 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1

1 of part B of title XXVII of the Public Health Service Act  
2 is amended by adding at the end the following new section:

3 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**  
4 **THIRD PARTY REVIEW IN CERTAIN CASES.**

5 “(a) NOTICE AND REVIEW RIGHT.—If a health in-  
6 surance issuer determines to nonrenew or not continue in  
7 force, including rescind, health insurance coverage for an  
8 individual in the individual market on the basis described  
9 in section 2742(b)(2) before such nonrenewal, discontinu-  
10 ation, or rescission, may take effect the issuer shall pro-  
11 vide the individual with notice of such proposed non-  
12 renewal, discontinuation, or rescission and an opportunity  
13 for a review of such determination by an independent, ex-  
14 ternal third party under procedures specified by the Sec-  
15 retary.

16 “(b) INDEPENDENT DETERMINATION.—If the indi-  
17 vidual requests such review by an independent, external  
18 third party of a nonrenewal, discontinuation, or rescission  
19 of health insurance coverage, the coverage shall remain in  
20 effect until such third party determines that the coverage  
21 may be nonrenewed, discontinued, or rescinded under sec-  
22 tion 2742(b)(2).”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply after the date of the enactment

1 of this Act with respect to health insurance coverage  
2 issued before, on, or after such date.

Passed the House of Representatives September 25,  
2008.

Attest:                      LORRAINE C. MILLER,  
*Clerk.*