

111<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 2457

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

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## IN THE HOUSE OF REPRESENTATIVES

MAY 18, 2009

Mrs. DAVIS of California (for herself, Mr. McCOTTER, Mr. RUSH, Mr. WITTMAN, and Mr. HARE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor 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 Employee Retirement Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code to require that group health plans and issuers of health insurance coverage 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 “Right to a Second  
5 Medical Opinion Act of 2009”.

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

2 (a) GROUP HEALTH PLANS.—

3 (1) ERISA AMENDMENTS.—

4 (A) Subpart B of part 7 of title I of the  
5 Employee Retirement Income Security Act of  
6 1974 (29 U.S.C. 1185 et seq.) is amended by  
7 adding at the end the following new section:

8 **“SEC. 715. COVERAGE OF SECOND OPINIONS.**

9 “(a) COVERAGE OF SECOND OPINIONS.—A group  
10 health plan, and a health insurance issuer that provides  
11 health insurance coverage in connection with a group  
12 health plan, shall provide coverage for a second opinion  
13 (as defined in subsection (b)(1)), if—

14 “(1) the second opinion is requested by—

15 “(A) a participant or beneficiary; or

16 “(B) a health care practitioner (as defined  
17 in subsection (b)(2))—

18 “(i) who, with respect to a medical  
19 condition, is treating or has proposed a  
20 treatment plan for the participant or bene-  
21 ficiary; and

22 “(ii) who has the consent of the par-  
23 ticipant or beneficiary to make the request;  
24 and

25 “(2)(A) the participant or beneficiary questions  
26 a diagnosis, treatment plan, surgical procedure, or

1 therapeutic procedure for a medical condition that  
2 threatens loss of life, quality of life, loss of limb, loss  
3 of bodily function, loss of cognitive function, or sub-  
4 stantial impairment of the mind or body (including  
5 a serious chronic condition or infection);

6 “(B) the clinical indications with respect to a  
7 medical condition are not conclusive;

8 “(C) a diagnosis for a medical condition is in  
9 doubt due to conflicting test results;

10 “(D) the health care practitioner treating the  
11 participant or beneficiary for a medical condition is  
12 unable to diagnose the condition;

13 “(E) the treatment plan being used by the par-  
14 ticipant or beneficiary for a medical condition is not  
15 causing improvement in the condition within an ap-  
16 propriate period of time given the diagnosis and plan  
17 of care as expected for such condition; or

18 “(F) the medical condition under treatment ac-  
19 celerates or continues.

20 “(b) COVERAGE OF A SECOND OPINION AND RE-  
21 LATED DEFINITIONS.—For purposes of this section:

22 “(1) COVERAGE OF A SECOND OPINION.—The  
23 term ‘coverage of a second opinion’ means, with re-  
24 spect to a medical condition, coverage for—

1           “(A) at least three appointments for the  
2 participant or beneficiary with the qualified sec-  
3 ond opinion physician (as defined in paragraph  
4 (7)) for the purposes of making and reviewing  
5 a second opinion (as defined in paragraph (8))  
6 for the medical condition; and

7           “(B) ancillary diagnostic tests conducted  
8 or ordered by the qualified second opinion phy-  
9 sician for the purpose of making such second  
10 opinion to the extent such tests would be cov-  
11 ered by the plan or issuer involved if the tests  
12 were conducted to provide information to a par-  
13 ticipating physician (as defined in paragraph  
14 (5)) for the purpose of making the initial opin-  
15 ion (as defined in paragraph (3)) with respect  
16 to the medical condition.

17           “(2) HEALTH CARE PRACTITIONER.—The term  
18 ‘health care practitioner’ means a physician or a  
19 nurse practitioner.

20           “(3) INITIAL OPINION.—The term ‘initial opin-  
21 ion’ means, with respect to a medical condition, the  
22 first opinion for such condition.

23           “(4) OPINION.—The term ‘opinion’ means, for  
24 a medical condition, an opinion respecting the diag-  
25 nosis or treatment plan for the condition that is

1 made by a health care practitioner for a participant  
2 or beneficiary.

3 “(5) PARTICIPATING PHYSICIAN.—The term  
4 ‘participating physician’ means, with respect to a  
5 group health plan or an issuer of health insurance  
6 coverage, a physician who participates in a preferred  
7 physician network (or similar arrangement) recog-  
8 nized under such coverage of a plan or issuer.

9 “(6) PHYSICIAN.—The term ‘physician’ has the  
10 meaning given such term in section 1861(r)(1) of  
11 the Social Security Act (42 U.S.C. 1935x(r)(1)).

12 “(7) QUALIFIED SECOND OPINION PHYSI-  
13 CIAN.—The term ‘qualified second opinion physi-  
14 cian’ means, with respect to a medical condition, a physi-  
15 cian who possesses a clinical background, including  
16 training and expertise or a history of treating pa-  
17 tients, related to the condition.

18 “(8) SECOND OPINION.—The term ‘second  
19 opinion’ means, with respect to a medical condition,  
20 an opinion made by a qualified second opinion physi-  
21 cian for a medical condition for which another health  
22 care practitioner (as defined in paragraph (2)) made  
23 an initial opinion (as defined in paragraph (3)).

24 “(c) FINANCIAL RESPONSIBILITY, TERMS OF COV-  
25 ERAGE, AND LIMITATIONS.—

1           “(1) FINANCIAL RESPONSIBILITY.—

2                   “(A) PARTICIPANT.—The financial respon-  
3                   sibility of the participant or beneficiary (includ-  
4                   ing deductibles, coinsurance, co-payments, and  
5                   other cost sharing) under a group health plan  
6                   or health insurance coverage for a second opin-  
7                   ion under subsection (a) shall be the same as  
8                   the financial responsibility of the participant or  
9                   beneficiary under such plan or coverage for  
10                  comparable services furnished by a participating  
11                  physician in connection with an initial opinion.

12                  “(B) PLAN OR ISSUER.—Subject to para-  
13                  graph (3), the plan or issuer of health insur-  
14                  ance coverage shall reimburse the second opin-  
15                  ion physician for the total costs of the physi-  
16                  cian’s services that are in excess of the financial  
17                  responsibility of the participant under subpara-  
18                  graph (A).

19                  “(2) TERMS OF COVERAGE.—The terms of cov-  
20                  erage under a group health plan or health insurance  
21                  coverage for a second opinion under subsection (a)  
22                  shall be the same as the terms of coverage under  
23                  such plan or coverage for an initial opinion made by  
24                  a participating physician.

1           “(3) USE OF NETWORKS.—The plan or issuer  
2           may limit coverage of a second opinion to a partici-  
3           pating physician, but only if there is a participating  
4           physician who—

5                   “(A) is a qualified second opinion physi-  
6                   cian, for purposes of the second opinion re-  
7                   quested under subsection (a)(1);

8                   “(B) is located within 50 miles of the  
9                   home of the participant or beneficiary with re-  
10                  spect to which a request was made under sub-  
11                  section (a)(1); and

12                  “(C) has an initial appointment available  
13                  for such participant or beneficiary within 30  
14                  days of date on which such request was made.

15           “(4) PREAPPROVAL.—

16                   “(A) IN GENERAL.—Subject to subpara-  
17                   graph (B) and subsection (e), the plan or issuer  
18                   may require preapproval for the second opinion  
19                   from the plan or issuer, but only in accordance  
20                   with this paragraph and with paragraph (2).

21                   “(B) RULES FOR PREAPPROVAL.—

22                           “(i) NOTICE OF APPROVAL OR DE-  
23                           NIAL.—A plan or issuer that requires  
24                           preapproval of second opinions shall pro-  
25                           vide notice to the participant or beneficiary

1 about the plan or issuer’s decision con-  
2 cerning a request for preapproval of a sec-  
3 ond opinion for such participant or bene-  
4 ficiary not later than 10 business days  
5 after the date on which the participant or  
6 beneficiary requests the preapproval.

7 “(ii) PROHIBITION.—A plan or issuer  
8 may not require preapproval of a second  
9 opinion if the participant or beneficiary re-  
10 questing such approval faces an imminent  
11 threat to health (including the potential  
12 loss of life, limb, major bodily function)  
13 and a delay in receiving a second opinion  
14 would be detrimental to the participant’s  
15 or beneficiary’s ability to regain maximum  
16 function. In such cases, the provider is re-  
17 quired to reimburse the beneficiary for the  
18 costs of the services and items described in  
19 subparagraphs (A) and (B) of subsection  
20 (b)(1) that are related to the second opin-  
21 ion, minus the allowable copayments deter-  
22 mined under paragraph (1), if the bene-  
23 ficiary paid for such opinion from personal  
24 sources.

1       “(d) CONSULTATION REPORT.—The plan or issuer  
2 may condition payment for the second opinion under sub-  
3 section (a) on the qualified second opinion physician pro-  
4 viding to the participant or beneficiary and to the health  
5 care practitioner who made the initial opinion a consulta-  
6 tion report that includes, with respect to the medical con-  
7 dition for which the second opinion was made, any diag-  
8 nosis of such condition made by the qualified second opin-  
9 ion physician and any recommended procedures, tests, or  
10 treatments that the qualified second opinion physician be-  
11 lieves are appropriate.

12       “(e) DENIAL OF COVERAGE OR PREAPPROVAL.—If a  
13 plan or issuer denies coverage for a second opinion or de-  
14 nies preapproval for a second opinion under subsection  
15 (c)(4), the plan or issuer shall, not later than 3 business  
16 days after the date of such denial—

17               “(1) notify the participant or beneficiary in  
18 writing of the reasons for the denial;

19               “(2) inform the participant or beneficiary of  
20 such participant’s or beneficiary’s right to file an ap-  
21 peal with the plan or issuer; and

22               “(3) inform the participant or beneficiary of the  
23 process for appealing the denial.

24       “(f) APPEALS.—

1           “(1) IN GENERAL.—The plan or issuer shall es-  
2           tablish a process for a participant or beneficiary to  
3           appeal when preapproval for a second opinion or  
4           coverage of a second opinion is denied by the plan  
5           or issuer.

6           “(2) REPORT TO SECRETARY.—No later than  
7           90 days after the date of enactment of this section,  
8           the plan or issuer shall submit to the Secretary a re-  
9           port describing the appeal process developed by the  
10          plan or issuer under paragraph (1).

11          “(g) TIMELINES REQUIRED.—

12           “(1) IN GENERAL.—Not later than 90 days  
13           after the date of enactment of this section and not  
14           later than 30 days after the date a timeline required  
15           under this subsection is amended, each plan or  
16           issuer shall file with the Secretary a timeline for—

17                   “(A) providing reimbursement of claims  
18                   submitted for second opinions; and

19                   “(B) if required by the plan or issuer, re-  
20                   sponding to requests for preapproval of second  
21                   opinions under subsection (c)(4).

22           “(2) PUBLIC AVAILABILITY.—Any timeline filed  
23           under paragraph (1) shall be available to the public  
24           upon request.

1       “(h) NOTICE.—The imposition of the requirement of  
2 this section shall be treated as a material modification in  
3 the terms of the plan described in section 102(a), for pur-  
4 poses of assuring notice of such requirements under the  
5 plan; except that the summary description required to be  
6 provided under the last sentence of section 104(b)(1) with  
7 respect to such modification shall be provided by not later  
8 than 60 days after the first day of the first plan year in  
9 which such requirements apply.

10       “(i) CONSTRUCTION REGARDING ADDITIONAL OPIN-  
11 IONS.—Nothing in this section shall be construed to pre-  
12 vent the plan or issuer, based on its independent deter-  
13 mination, from providing coverage to a participant or ben-  
14 efiary for additional medical opinions.

15       “(j) SERVICE PLAN CONTACTS.—The Secretary shall  
16 deem health care service plan contracts that provide bene-  
17 fits to participants or beneficiaries through preferred prac-  
18 titioner contracting arrangements to have satisfied the re-  
19 quirements of this section if, subject to all other terms  
20 and conditions of the contract that apply generally to all  
21 other benefits, access to and coverage for second opinions  
22 is not limited.”.

23               (B) Section 731(c) of such Act (29 U.S.C.  
24       1191(c)) is amended by striking “section 711” and  
25       inserting “sections 711 and 715”.

1 (C) Section 732(a) of such Act (29 U.S.C.  
2 1191a(a)) is amended by striking “section 711” and  
3 inserting “sections 711 and 715”.

4 (D) The table of contents in section 1 of such  
5 Act is amended by inserting after the item relating  
6 to section 714 the following new item:

“Sec. 715. Coverage of second opinions.”.

7 (2) PUBLIC HEALTH SERVICE ACT AMEND-  
8 MENTS.—

9 (A) IN GENERAL.—Subpart 2 of part A of  
10 title XXVII of the Public Health Service Act  
11 (42 U.S.C. 300gg–4 et seq.) is amended by  
12 adding at the end the following new section:

13 **“SEC. 2708 COVERAGE OF SECOND OPINIONS.**

14 “The provisions of section 715 of the Employee Re-  
15 tirement Income Security Act of 1974, except for sub-  
16 section (h) of such section, shall apply to group health  
17 plans, and health insurance issuers providing health insur-  
18 ance coverage in connection with group health plans, as  
19 if included in this subpart.”.

20 (B) CLERICAL AMENDMENT.—Section  
21 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is  
22 amended by striking “section 2704” and insert-  
23 ing “sections 2704 and 2708”.

24 (3) INTERNAL REVENUE CODE AMEND-  
25 MENTS.—

1 (A) IN GENERAL.—Subchapter B of chap-  
2 ter 100 of the Internal Revenue Code of 1986  
3 (26 U.S.C. 9811 et seq.) is amended by adding  
4 at the end the following:

5 **“SEC. 9814 COVERAGE OF SECOND OPINIONS.**

6 “The provisions of section 715 of the Employee Re-  
7 tirement Income Security Act of 1974, except for sub-  
8 section (h) of such section, shall apply to group health  
9 plans as if included in this subchapter.”.

10 (B) CONFORMING AMENDMENT.—The  
11 table of sections for subchapter B of chapter  
12 100 of such Code is amended by inserting after  
13 the item relating to section 9813 the following  
14 new item:

“Sec. 9814. Coverage of second opinions.”.

15 (b) INDIVIDUAL HEALTH INSURANCE.—

16 (1) IN GENERAL.—Subpart 2 of part B of title  
17 XXVII of the Public Health Service Act is amended  
18 by inserting at the end the following new section:

19 **“SEC. 2754 COVERAGE OF SECOND OPINIONS.**

20 “The provisions of section 2708 shall apply to health  
21 insurance coverage offered by a health insurance issuer  
22 in the individual market in the same manner as such pro-  
23 visions apply to health insurance coverage offered by a  
24 health insurance issuer in connection with a group health  
25 plan in the small or large group market.”.

1           (2) CONFORMING AMENDMENT.—Section  
2           2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))  
3           is amended by striking “section 2751” and inserting  
4           “sections 2751 and 2754”.

5           (c) COORDINATION OF ADMINISTRATION.—The Sec-  
6           retary of Labor, the Secretary of the Treasury, and the  
7           Secretary of Health and Human Services shall ensure,  
8           through the execution of an interagency memorandum of  
9           understanding among such Secretaries, that—

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

16           (2) the enforcement of such regulations, rul-  
17           ings, and interpretations is coordinated by such Sec-  
18           retaries for the purposes of having a consistent en-  
19           forcement strategy that avoids duplication of en-  
20           forcement efforts and assigns priorities in enforce-  
21           ment.

22           (d) EFFECTIVE DATES.—

23           (1) GROUP HEALTH PLANS AND GROUP  
24           HEALTH INSURANCE COVERAGE.—Subject to para-  
25           graph (3), the amendments made by subsection (a)

1 apply with respect to group health plans for plan  
2 years beginning on or after January 1, 2010.

3 (2) INDIVIDUAL HEALTH INSURANCE COV-  
4 ERAGE.—The amendments made by subsection (b)  
5 apply with respect to health insurance coverage of-  
6 fered, sold, issued, renewed, in effect, or operated in  
7 the individual market on or after January 1, 2010.

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

16 (A) the date on which the last collective  
17 bargaining agreement relating to the plan ter-  
18 minates (determined without regard to any ex-  
19 tension thereof agreed to after the date of the  
20 enactment of this Act), or

21 (B) January 1, 2010.

22 For purposes of subparagraph (A), any plan amend-  
23 ment made pursuant to a collective bargaining  
24 agreement relating to the plan which amends the  
25 plan solely to conform to any requirement added by

- 1 subsection (a) shall not be treated as a termination
- 2 of such collective bargaining agreement.

○