

112TH CONGRESS
1ST SESSION

H. R. 111

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.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 2011

Ms. DELAURO (for herself, Mr. BARTON of Texas, Mr. ACKERMAN, Mr. BACA, Ms. BALDWIN, Mr. BARROW, Ms. BERKLEY, Mr. BERMAN, Mr. BISHOP of Georgia, Mr. BOREN, Mr. BRALEY of Iowa, Ms. BROWN of Florida, Mrs. CAPPS, Mr. CARSON of Indiana, Ms. CASTOR of Florida, Mr. CLEAVER, Mr. CLYBURN, Mr. COHEN, Mr. CONNOLLY of Virginia, Mr. CRITZ, Mr. DINGELL, Mr. DONNELLY of Indiana, Ms. EDWARDS, Mr. ELLISON, Mr. ENGEL, Mr. FARR, Mr. FRANK of Massachusetts, Ms. FUDGE, Mr. GRIJALVA, Mr. HIMES, Ms. HIRONO, Mr. HOLT, Mr. ISRAEL, Mr. JACKSON of Illinois, Ms. JACKSON LEE of Texas, Mr. JOHNSON of Georgia, Mr. JONES, Mr. KILDEE, Mr. KIND, Mr. KISSELL, Mr. LANGEVIN, Mr. LARSEN of Washington, Mr. LARSON of Connecticut, Ms. LEE of California, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LOEBSACK, Ms. ZOE LOFGREN of California, Mrs. LOWEY, Mrs. MALONEY, Mrs. MCCARTHY of New York, Mr. MCDERMOTT, Mr. MCGOVERN, Mr. MCINTYRE, Mr. MEEKS, Mr. MILLER of North Carolina, Ms. MOORE, Mr. MORAN, Mr. MURPHY of Connecticut, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEAL, Mr. OLVER, Mr. PASTOR of Arizona, Mr. PAYNE, Mr. RANGEL, Ms. ROYBAL-ALLARD, Mr. RUPPERSBERGER, Mr. RUSH, Mr. RYAN of Ohio, Mr. SABLAN, Ms. LINDA T. SANCHEZ of California, Ms. SCHAKOWSKY, Mr. SCHIFF, Mrs. SCHMIDT, Ms. SCHWARTZ, Mr. DAVID SCOTT of Georgia, Mr. SERRANO, Mr. SHERMAN, Ms. SLAUGHTER, Ms. SPEIER, Mr. STARK, Ms. SUTTON, Mr. TOWNS, Mr. VAN HOLLEN, Ms. WASSERMAN SCHULTZ, Mr. WEINER, Mr. WELCH, Mr. WU, Mr. YARMUTH, Mr. YOUNG of Alaska, Ms. PINGREE of Maine, Mr. SMITH of Washington, Mr. PRICE of North Carolina, Mr. CHANDLER, and Ms. EDDIE BERNICE JOHNSON of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and the Workforce, 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 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,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Breast Cancer Patient
5 Protection Act of 2011”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

8 (1) According to the American Cancer Society,
9 excluding cancers of the skin, breast cancer is the
10 most frequently diagnosed cancer in women.

11 (2) According to the American Cancer Society,
12 an estimated 40,480 women and 450 men died from
13 breast cancer in 2008.

14 (3) According to the American Cancer Society,
15 in 2008 an estimated 182,460 new cases of invasive
16 breast cancer were diagnosed in women, and an esti-
17 mated 1,990 invasive breast cancer cases were diag-
18 nosed in men; and in addition, an estimated 67,770
19 new cases of in situ breast cancer occurred in
20 women in 2008, and of these, approximately 85 per-
21 cent were ductal carcinoma in situ.

1 (4) According to the American Cancer Society,
2 most breast cancer patients undergo some type of
3 surgical treatment, which may involve lumpectomy
4 (surgical removal of the tumor with clear margins)
5 or mastectomy (surgical removal of the breast) with
6 removal of some of the axillary (underarm) lymph
7 nodes.

8 (5) The offering and operation of health plans
9 affect commerce among the States.

10 (6) Health care providers located in a State
11 serve patients who reside in the State and patients
12 who reside in other States.

13 (7) In order to provide for uniform treatment
14 of health care providers and patients among the
15 States, it is necessary to cover health plans oper-
16 ating in one State as well as health plans operating
17 among the several States.

18 (8) Research has indicated that treatment for
19 breast cancer varies according to type of insurance
20 coverage and State of residence.

21 (9) Currently, 20 States mandate minimum in-
22 patient coverage after a patient undergoes a mastec-
23 tomy.

24 (10) Breast cancer patients have reported ad-
25 verse outcomes, including infection and inadequately

1 controlled pain, resulting from premature hospital
2 discharge following breast cancer surgery.

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

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

9 **“SEC. 716. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
10 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
11 **AND LYMPH NODE DISSECTIONS FOR THE**
12 **TREATMENT OF BREAST CANCER AND COV-**
13 **ERAGE FOR SECONDARY CONSULTATIONS.**

14 “(a) INPATIENT CARE.—

15 “(1) IN GENERAL.—A group health plan, and a
16 health insurance issuer providing health insurance
17 coverage in connection with a group health plan,
18 that provides medical and surgical benefits shall en-
19 sure that inpatient (and in the case of a
20 lumpectomy, outpatient) coverage and radiation
21 therapy is provided for breast cancer treatment.

22 Such plan or coverage may not—

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

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

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

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

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

20 “(b) PROHIBITION ON CERTAIN MODIFICATIONS.—
21 In implementing the requirements of this section, a group
22 health plan, and a health insurance issuer providing health
23 insurance coverage in connection with a group health plan,
24 may not modify the terms and conditions of coverage
25 based on the determination by a participant or beneficiary

1 to request less than the minimum coverage required under
2 subsection (a).

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

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

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

16 whichever is earlier.

17 “(d) SECONDARY CONSULTATIONS.—

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

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

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

1 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
2 A group health plan, and a health insurance issuer pro-
3 viding health insurance coverage in connection with a
4 group health plan, may not—

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

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

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

22 (b) CLERICAL AMENDMENT.—The table of contents
23 in section 1 of the Employee Retirement Income Security
24 Act of 1974 is amended by inserting after the item relat-
25 ing to section 715 the following:

“Sec. 716. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.”.

1 (c) EFFECTIVE DATES.—

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

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

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

3 (a) IN GENERAL.—Title XXVII of the Public Health
 4 Service Act is amended by inserting after section 2728 of
 5 such Act (42 U.S.C. 300gg–28), as redesignated by sec-
 6 tion 1001(2) of the Patient Protection and Affordable
 7 Care Act (Public Law 111–148), the following:

8 **“SEC. 2729. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
 9 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
 10 **AND LYMPH NODE DISSECTIONS FOR THE**
 11 **TREATMENT OF BREAST CANCER AND COV-**
 12 **ERAGE FOR SECONDARY CONSULTATIONS.**

13 “(a) INPATIENT CARE.—

14 “(1) IN GENERAL.—A group health plan, and a
 15 health insurance issuer providing group or individual
 16 health insurance coverage, that provides medical and
 17 surgical benefits shall ensure that inpatient (and in
 18 the case of a lumpectomy, outpatient) coverage and
 19 radiation therapy is provided for breast cancer treat-
 20 ment. 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 group
20 or individual health insurance coverage, may not modify
21 the terms and conditions of coverage based on the deter-
22 mination by a participant or beneficiary to request less
23 than the minimum coverage required under subsection (a).

24 “(c) NOTICE.—A group health plan, and a health in-
25 surance issuer providing group or individual health insur-

1 ance coverage, shall provide notice to each participant and
2 beneficiary under such plan or coverage regarding the cov-
3 erage required by this section in accordance with regula-
4 tions promulgated by the Secretary. Such notice shall be
5 in writing and prominently positioned in the summary of
6 the plan or coverage made available or distributed by the
7 plan or issuer and shall be transmitted—

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

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

12 whichever is earlier.

13 “(d) SECONDARY CONSULTATIONS.—

14 “(1) IN GENERAL.—A group health plan, and a
15 health insurance issuer providing group or individual
16 health insurance coverage, that provides coverage
17 with respect to medical and surgical services pro-
18 vided in relation to the diagnosis and treatment of
19 cancer shall ensure that coverage is provided for sec-
20 ondary consultations, on terms and conditions that
21 are no more restrictive than those applicable to the
22 initial consultations, by specialists in the appropriate
23 medical fields (including pathology, radiology, and
24 oncology) to confirm or refute such diagnosis. Such
25 plan or issuer shall ensure that coverage is provided

1 for such secondary consultation whether such con-
2 sultation is based on a positive or negative initial di-
3 agnosis. In any case in which the attending physi-
4 cian certifies in writing that services necessary for
5 such a secondary consultation are not sufficiently
6 available from specialists operating under the plan
7 or coverage with respect to whose services coverage
8 is otherwise provided under such plan or by such
9 issuer, such plan or issuer shall ensure that coverage
10 is provided with respect to the services necessary for
11 the secondary consultation with any other specialist
12 selected by the attending physician for such purpose
13 at no additional cost to the individual beyond that
14 which the individual would have paid if the specialist
15 was participating in the network of the plan.

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

20 “(e) PROHIBITION ON PENALTIES OR INCENTIVES.—
21 A group health plan, and a health insurance issuer pro-
22 viding group or individual health insurance coverage, may
23 not—

24 “(1) penalize or otherwise reduce or limit the
25 reimbursement of a provider or specialist because

1 the provider or specialist provided care to a partici-
2 pant or beneficiary in accordance with this section;

3 “(2) provide financial or other incentives to a
4 physician or specialist to induce the physician or
5 specialist to keep the length of inpatient stays of pa-
6 tients following a mastectomy, lumpectomy, or a
7 lymph node dissection for the treatment of breast
8 cancer below certain limits or to limit referrals for
9 secondary consultations; or

10 “(3) provide financial or other incentives to a
11 physician or specialist to induce the physician or
12 specialist to refrain from referring a participant or
13 beneficiary for a secondary consultation that would
14 otherwise be covered by the plan or coverage in-
15 volved under subsection (d).”.

16 (b) EFFECTIVE DATES.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply with respect to plan years be-
19 ginning on or after 90 days after the date of enact-
20 ment of this Act.

21 (2) SPECIAL RULE FOR COLLECTIVE BAR-
22 GAINING AGREEMENTS.—In the case of a group
23 health plan maintained pursuant to 1 or more collec-
24 tive bargaining agreements between employee rep-
25 resentatives and 1 or more employers ratified before

1 the date of enactment of this Act, the amendments
 2 made by this section shall not apply to plan years
 3 beginning before the date on which the last collective
 4 bargaining agreements relating to the plan termi-
 5 nates (determined without regard to any extension
 6 thereof agreed to after the date of enactment of this
 7 Act). For purposes of this paragraph, any plan
 8 amendment made pursuant to a collective bargaining
 9 agreement relating to the plan which amends the
 10 plan solely to conform to any requirement added by
 11 this section shall not be treated as a termination of
 12 such collective bargaining agreement.

13 **SEC. 5. AMENDMENTS TO THE INTERNAL REVENUE CODE**
 14 **OF 1986.**

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

17 (1) in the table of sections, by inserting after
 18 the item relating to section 9813 the following:

“Sec. 9814. Required coverage for minimum hospital stay for mastectomies,
 lumpectomies, and lymph node dissections for the treatment of
 breast cancer and coverage for secondary consultations.”;

19 and

20 (2) by inserting after section 9813 the fol-
 21 lowing:

1 **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**
2 **STAY FOR MASTECTOMIES, LUMPECTOMIES,**
3 **AND LYMPH NODE DISSECTIONS FOR THE**
4 **TREATMENT OF BREAST CANCER AND COV-**
5 **ERAGE FOR SECONDARY CONSULTATIONS.**

6 “(a) INPATIENT CARE.—

7 “(1) IN GENERAL.—A group health plan that
8 provides medical and surgical benefits shall ensure
9 that inpatient (and in the case of a lumpectomy,
10 outpatient) coverage and radiation therapy is pro-
11 vided for breast cancer treatment. Such plan may
12 not—

13 “(A) insofar as the attending physician, in
14 consultation with the patient, determines it to
15 be medically necessary—

16 “(i) restrict benefits for any hospital
17 length of stay in connection with a mastec-
18 tomy or breast conserving surgery (such as
19 a lumpectomy) for the treatment of breast
20 cancer to less than 48 hours; or

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

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

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

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

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

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

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

4 “(d) SECONDARY CONSULTATIONS.—

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

1 with any other specialist selected by the attending
2 physician for such purpose at no additional cost to
3 the individual beyond that which the individual
4 would have paid if the specialist was participating in
5 the network of the plan.

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

10 “(e) PROHIBITION ON PENALTIES.—A group health
11 plan may not—

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

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

23 “(3) provide financial or other incentives to a
24 physician or specialist to induce the physician or
25 specialist to refrain from referring a participant or

1 beneficiary for a secondary consultation that would
2 otherwise be covered by the plan involved under sub-
3 section (d).”.

4 (b) EFFECTIVE DATES.—

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

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

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

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

10 (1) in its heading, by inserting “**AND CON-**
11 **TINUATION IN FORCE, INCLUDING PROHIBI-**
12 **TION OF RESCISSION,**” after “**GUARANTEED RE-**
13 **NEWABILITY**”;

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

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

21 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL
22 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1
23 of part B of title XXVII of the Public Health Service Act
24 is amended by adding at the end the following new section:

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

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

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

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply after the date of the enactment
23 of this Act with respect to health insurance coverage
24 issued before, on, or after such date.

○