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111TH CONGRESS
1ST 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.

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.

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 ''Right to a Second Medical Opinion Act of 2009''.

SEC. 2. COVERAGE OF SECOND OPINIONS.

(a) GROUP HEALTH PLANS.—

(1) ERISA AMENDMENTS.—

(A) Subpart B of part 7 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 new section:

"SEC. 715. COVERAGE OF SECOND OPINIONS.

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

"(1) the second opinion is requested by—

"(A) a participant or beneficiary; or

"(B) a health care practitioner (as defined in subsection (b)(2))—

"(i) who, with respect to a medical condition, is treating or has proposed a treatment plan for the participant or beneficiary; and

"(ii) who has the consent of the participant or beneficiary to make the request; and

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

therapeutic procedure for a medical condition that threatens loss of life, quality of life, loss of limb, loss of bodily function, loss of cognitive function, or substantial impairment of the mind or body (including a serious chronic condition or infection);

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

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

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

''(E) the treatment plan being used by the participant or beneficiary for a medical condition is not causing improvement in the condition within an appropriate period of time given the diagnosis and plan of care as expected for such condition; or

''(F) the medical condition under treatment accelerates or continues.

''(b) COVERAGE OF A SECOND OPINION AND RELATED DEFINITIONS.—For purposes of this section:

''(1) COVERAGE OF A SECOND OPINION.—The term 'coverage of a second opinion' means, with respect to a medical condition, coverage for—

''(A) at least three appointments for the participant or beneficiary with the qualified second opinion physician (as defined in paragraph (7)) for the purposes of making and reviewing a second opinion (as defined in paragraph (8)) for the medical condition; and

''(B) ancillary diagnostic tests conducted or ordered by the qualified second opinion physician for the purpose of making such second opinion to the extent such tests would be covered by the plan or issuer involved if the tests were conducted to provide information to a participating physician (as defined in paragraph (5)) for the purpose of making the initial opinion (as defined in paragraph (3)) with respect to the medical condition.

''(2) HEALTH CARE PRACTITIONER.—The term 'health care practitioner' means a physician or a nurse practitioner.

''(3) INITIAL OPINION.—The term 'initial opinion' means, with respect to a medical condition, the first opinion for such condition.

''(4) OPINION.—The term 'opinion' means, for a medical condition, an opinion respecting the diagnosis or treatment plan for the condition that is

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

''(5) PARTICIPATING PHYSICIAN.—The term 'participating physician' means, with respect to a group health plan or an issuer of health insurance coverage, a physician who participates in a preferred physician network (or similar arrangement) recognized under such coverage of a plan or issuer.

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

''(7) QUALIFIED SECOND OPINION PHYSICIAN.—The term 'qualified second opinion physician' means, with respect to a medical condition, a physician who possesses a clinical background, including training and expertise or a history of treating patients, related to the condition.

''(8) SECOND OPINION.—The term 'second opinion' means, with respect to a medical condition, an opinion made by a qualified second opinion physician for a medical condition for which another health care practitioner (as defined in paragraph (2)) made an initial opinion (as defined in paragraph (3)).

''(c) FINANCIAL RESPONSIBILITY, TERMS OF COVERAGE, AND LIMITATIONS.—

''(1) FINANCIAL RESPONSIBILITY.—

''(A) PARTICIPANT.—The financial responsibility of the participant or beneficiary (including deductibles, coinsurance, co-payments, and other cost sharing) under a group health plan or health insurance coverage for a second opinion under subsection (a) shall be the same as the financial responsibility of the participant or beneficiary under such plan or coverage for comparable services furnished by a participating physician in connection with an initial opinion.

''(B) PLAN OR ISSUER.—Subject to paragraph (3), the plan or issuer of health insurance coverage shall reimburse the second opinion physician for the total costs of the physician's services that are in excess of the financial responsibility of the participant under subparagraph (A).

''(2) TERMS OF COVERAGE.—The terms of coverage under a group health plan or health insurance coverage for a second opinion under subsection (a) shall be the same as the terms of coverage under such plan or coverage for an initial opinion made by a participating physician.

''(3) USE OF NETWORKS.—The plan or issuer may limit coverage of a second opinion to a participating physician, but only if there is a participating physician who—

''(A) is a qualified second opinion physician, for purposes of the second opinion requested under subsection (a)(1);

''(B) is located within 50 miles of the home of the participant or beneficiary with respect to which a request was made under subsection (a)(1); and

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

''(4) PREAPPROVAL.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsection (e), the plan or issuer may require preapproval for the second opinion from the plan or issuer, but only in accordance with this paragraph and with paragraph (2).

''(B) RULES FOR PREAPPROVAL.—

''(i) NOTICE OF APPROVAL OR DENIAL.—A plan or issuer that requires preapproval of second opinions shall provide notice to the participant or beneficiary

about the plan or issuer's decision concerning a request for preapproval of a second opinion for such participant or beneficiary not later than 10 business days after the date on which the participant or beneficiary requests the preapproval.

''(ii) PROHIBITION.—A plan or issuer may not require preapproval of a second opinion if the participant or beneficiary requesting such approval faces an imminent threat to health (including the potential loss of life, limb, major bodily function) and a delay in receiving a second opinion would be detrimental to the participant's or beneficiary's ability to regain maximum function. In such cases, the provider is required to reimburse the beneficiary for the costs of the services and items described in subparagraphs (A) and (B) of subsection (b)(1) that are related to the second opinion, minus the allowable copayments determined under paragraph (1), if the beneficiary paid for such opinion from personal sources.

''(d) CONSULTATION REPORT.—The plan or issuer may condition payment for the second opinion under subsection (a) on the qualified second opinion physician providing to the participant or beneficiary and to the health care practitioner who made the initial opinion a consultation report that includes, with respect to the medical condition for which the second opinion was made, any diagnosis of such condition made by the qualified second opinion physician and any recommended procedures, tests, or treatments that the qualified second opinion physician believes are appropriate.

''(e) DENIAL OF COVERAGE OR PREAPPROVAL.—If a plan or issuer denies coverage for a second opinion or denies preapproval for a second opinion under subsection (c)(4), the plan or issuer shall, not later than 3 business days after the date of such denial—

''(1) notify the participant or beneficiary in writing of the reasons for the denial;

''(2) inform the participant or beneficiary of such participant's or beneficiary's right to file an appeal with the plan or issuer; and

''(3) inform the participant or beneficiary of the process for appealing the denial.

''(f) APPEALS.—

''(1) IN GENERAL.—The plan or issuer shall establish a process for a participant or beneficiary to appeal when preapproval for a second opinion or coverage of a second opinion is denied by the plan or issuer.

''(2) REPORT TO SECRETARY.—No later than 90 days after the date of enactment of this section, the plan or issuer shall submit to the Secretary a report describing the appeal process developed by the plan or issuer under paragraph (1).

''(g) TIMELINES REQUIRED.—

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

''(A) providing reimbursement of claims submitted for second opinions; and

''(B) if required by the plan or issuer, responding to requests for preapproval of second opinions under subsection (c)(4).

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

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

''(i) CONSTRUCTION REGARDING ADDITIONAL OPINIONS.—Nothing in this section shall be construed to prevent the plan or issuer, based on its independent determination, from providing coverage to a participant or beneficiary for additional medical opinions.

''(j) SERVICE PLAN CONTACTS.—The Secretary shall deem health care service plan contracts that provide benefits to participants or beneficiaries through preferred practitioner contracting arrangements to have satisfied the requirements of this section if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions is not limited.''.

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

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

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

''Sec. 715. Coverage of second opinions.''.

(2) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(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 new section:

''SEC. 2708 COVERAGE OF SECOND OPINIONS.

''The provisions of section 715 of the Employee Retirement Income Security Act of 1974, except for subsection (h) of such section, shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart.''.

(B) CLERICAL AMENDMENT.—Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (26 U.S.C. 9811 et seq.) is amended by adding at the end the following:

"SEC. 9814 COVERAGE OF SECOND OPINIONS.

''The provisions of section 715 of the Employee Retirement Income Security Act of 1974, except for subsection (h) of such section, shall apply to group health plans as if included in this subchapter.''.

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

''Sec. 9814. Coverage of second opinions.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

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

"SEC. 2754 COVERAGE OF SECOND OPINIONS.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as such provisions 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.''.

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

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

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

(2) the enforcement of such regulations, rulings, and interpretations is coordinated by such Secretaries for the purposes of having a consistent enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(d) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—Subject to paragraph (3), the amendments made by subsection (a)

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

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by subsection (b) apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2010.

(3) COLLECTIVE BARGAINING EXCEPTION.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment of this Act, the amendments made to subsection (a) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by

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

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