range of activities under the North Korean Human Rights Act, which includes, in the words of the act: ''Promoting the Human Rights of North Koreans''; ''Assisting North Koreans in Need''; and ''Protecting North Korean Refugees.''

The people of North Korea face some of the most severe repression on the planet.

I am proud of the work that our Congress began 4 years ago to help their plight, and I thank my friend Chairman BERMAN, our bipartisan cosponsors, and the numerous nongovernmental organizations who have worked with us to extend and improve the North Korean Human Rights Act.

I urge unanimous support for this measure.

Mr. Speaker, I reserve the balance of our time.

GENERAL LEAVE

Mr. SCOTT of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 5834.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. SCOTT of Georgia. And a final comment, Mr. Speaker. House Resolution 5834 indeed gives us an ambassador rank for human rights in North Korea. This is extraordinarily important, and this is not just right and needed for the people of North Korea. It's needed and it's right for all freedom-loving people on this planet, for us to move forthrightly and to be able to finally make this a critical, key part of our foreign policy.

Mr. Speaker, I have no further speakers, and I reserve the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, to help explain the intent behind the full-time special envoy requirement in this bill, I would like to insert into the RECORD a brief excerpt from the Background and Purpose section of House Report 110–628 submitted to the House by Chairman BERMAN.

NORTH KOREAN HUMAN RIGHTS REAUTHORIZATION ACT OF 2008

BACKGROUND AND PURPOSE FOR THE LEGISLATION

Executive Branch implementation of the refugee provisions of the 2004 Act has been too slow and too weak. On February 21, 2006, a bipartisan group of 9 senior House Members and Senators—including the then-Chairman and Ranking Member of the Committee on International Relations and the Chairman and Ranking Member of the Subcommittee on Asia and the Pacific—wrote the Secretary of State 'to express our deep concern for the lack of progress in funding and implementing the key provisions of the North Korean Human Rights Act.' Foremost among their concerns, they noted that, 'despite the fact that the Act calls for the Department of State to facilitate the submission of North Korean refugee applications, not one North Korean has been offered asylum or refugee status in the 16 months since the unanimous passage of the legislation.' The first North Korean refugees did not arrive in the United States until 3 months later, in May 2006.

North Koreans who have requested resettlement in the United States as refugees have also faced extended delays, in some cases longer than 2 years, while residing in circumstances that are frequently unsafe, unhealthy, and insecure. Delays sometimes continue even after the refugees have passed U.S. assessment and security screening, due to foot-dragging in the issuance of exit visas by the governments of the countries where they are located. These delays have been the source of considerable discouragement, frustration, and anxiety among North Korean refugees. Just last month a group of North Koreans awaiting U.S. resettlement in Thailand reportedly conducted a hunger strike in an attempt to obtain information about the status of their cases.

In the intervening 3½ years since the 2004 Act became law, the United States has resettled fewer than 50 North Korean refugees. This does not constitute the 'credible number of North Korean refugees [to be accepted] for domestic resettlement' contemplated by House Report 108–478.

During that same time frame, the United States, which has the largest refugee resettlement program in the world by far, has resettled approximately 150,000 other refugees from around the world. The United States is also home to the largest ethnic Korean community outside of the Korean peninsular region, and many of the 2–million-strong Korean-American community have family ties to North Korea. During the same period, South Korea has resettled approximately 6,000 North Koreans.

Remedying this situation will require more persistent U.S. diplomacy at more senior levels. At present, the number of foreign governments who allow the United States to process North Koreans in their countries for resettlement is extremely limited. Having a greater number of countries in which the United States can screen and process North Korean refugees for domestic resettlement will reduce the burdens that such cooperation may pose to each individual country. The United States must make it clear that this is a humanitarian and foreign policy priority, and demonstrate a willingness to use the refugee assistance funds (authorized in section 203 of the 2004 Act and section 10 of the Reauthorization Act) to help mitigate the costs that such cooperation might impose on countries that agree to allow U.S. resettlement processing.

To further the purposes of the 2004 Act, it is also important to clarify and strengthen the role of the Special Envoy. Regrettably, the President did not appoint a Special Envoy for North Korean Human Rights Issues until August 19, 2005, more than 4 months after the Special Envoy was required to report to Congress under the 2004 Act. The Special Envoy appointed by the President has filled that position on a part-time basis only, and has continued to live and pursue a career outside of Washington, D.C. Looking ahead to the possibility of a Special Envoy who may not enjoy the same preexisting rapport with and access to the President, it is important to ensure that any successor has adequate stature and presence within the Department of State. An active presence at Main State is necessary to ensure that the concerns at the heart of the Special Envoy's mandate are adequately represented in the decision-making processes of the State Department's regional and functional bureaus, especially the Bureau of East Asian and Pacific Affairs (EAP) and the Bureau of Population, Refugees, and Migration (PRM).

I have no further requests for time, and I yield back the balance of our time, Mr. Speaker.

Mr. SCOTT of Georgia. I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Georgia (Mr. SCOTT) that the House suspend the rules and concur in the Senate amendments to the bill, H.R. 5834.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the Senate amendments were concurred in.

A motion to reconsider was laid on the table.

BREAST CANCER PATIENT PROTECTION ACT OF 2008

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 758) 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, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 758

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Breast Cancer Patient Protection Act of 2008''.

SEC. 2. FINDINGS.

Congress finds that—

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

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

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

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

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

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

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

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

''SEC. 714. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and

surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

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

''(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

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

''(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

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

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in the summary of the plan made available or distributed by the plan or issuer and shall be transmitted—

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

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

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following:

''Sec. 714. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

(c) EFFECTIVE DATES.—

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

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

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

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

''SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan or coverage may not—

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

''(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

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

''(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

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

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in the summary of the plan made available or distributed by the plan or issuer and shall be transmitted—

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

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

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to group health plans for plan years beginning on or after 90 days after the date of enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 5. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

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

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

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

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

SEC. 6. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

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

(1) in the table of sections, by inserting after the item relating to section 9812 the following:

''Sec. 9813. Required coverage for minimum hospital stay for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.'';

and

(2) by inserting after section 9812 the following:

''SEC. 9813. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES, LUMPECTOMIES, AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy is provided for breast cancer treatment. Such plan may not—

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

''(i) restrict benefits for any hospital length of stay in connection with a mastectomy or breast conserving surgery (such as a lumpectomy) for the treatment of breast cancer to less than 48 hours; or

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

''(B) require that a provider obtain authorization from the plan for prescribing any length of stay required under this paragraph.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician, in consultation with the patient, determines that either a shorter period of hospital stay, or outpatient treatment, is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in the summary of the plan made available or distributed by the plan and shall be transmitted—

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

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

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that coverage is provided for secondary consultations, on terms and conditions that are no more restrictive than those applicable to the initial consultations, by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d).''.

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act). For purposes of this paragraph, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 7. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEWS OF CERTAIN NONRENEWALS AND DISCONTINUATIONS, INCLUDING RESCISSIONS, OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

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

(1) in its heading, by inserting ''**, CONTINUATION IN FORCE, INCLUDING PROHIBITION OF RESCISSION,**'' after ''**GUARANTEED RENEWABILITY**'';

(2) in subsection (a), by inserting '', including without rescission,'' after ''continue in force''; and

(3) in subsection (b)(2), by inserting before the period at the end the following: '', including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed''.

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

"SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

''(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to nonrenew or not continue in force, including rescind, health insurance coverage for an individual in the individual market on the basis described in section 2742(b)(2) before such nonrenewal, discontinuation, or rescission, may take effect the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

''(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal,discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).''.

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

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Texas (Mr. BURGESS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

I rise in strong support of the Breast Cancer Patient Protection Act of 2008, introduced by my good friend and colleague from Connecticut, Congresswoman ROSA DELAURO, and I know she's been working long and hard on this legislation. I am very pleased that we're bringing it up this evening.

This legislation is very important. It would provide protections for women across America who suffer from breast cancer.

Under the bill, doctors, in consultation with their patients, would decide the length of time the patient should remain in the hospital after having a mastectomy and other types of related procedures, and not the insurance company.

This legislation does not mandate hospitalization, but instead, restores the right of patients to consult with their physicians and decide how long she should be hospitalized, based on medical appropriateness.

Presently, 20 States have implemented minimum stay requirements to varying degrees. As a result, some people may question why this legislation is necessary. This bill is not for the women who live in States or have insurance policies that provide these protections. It is for the women who do not. For these women, a Federal remedy is their only hope. Having access to appropriate medical care should not be dependent on the State that you live in.

Mr. Speaker, for the thousands of American women diagnosed with breast cancer each year, this bill would help put an end to what has come to be known as drive-through mastectomies.

In addition, the bill clarifies existing law on when a health insurer can or cannot issue a decision of non-renewal, discontinue or rescind a health insurance policy. The bill would also create a new consumer protection by setting up a new independent review process for consumers in the individual health insurance market in the event of a non-renewal, discontinuation or rescission of a health insurance policy. Insurers would be required to continue coverage under such policy until completion of the independent review.

Once again, I want to thank my colleagues who have worked so hard on both of these bills, particularly Ms. DELAURO, the bill's sponsor; and I also want to thank the chairman of the Energy and Commerce Committee, Mr. DINGELL, who championed this cause during the patient's bill of rights debate, which some may remember—I certainly do. I also want to thank our friends in the minority, particularly Mr. BARTON and Mr. DEAL, for working across party lines to strengthen this bill. This is a very important bill, Mr. Speaker.

I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield such time as he may consume to the ranking member of the full committee, Mr. BARTON.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Thank you, Dr. BURGESS.

Mr. Speaker, I want to rise in strongest possible support for H.R. 758, the Breast Cancer Patient Protection Act.

As you know, as our distinguished subcommittee chairman Congressman PALLONE has already said, this bill will guarantee that every woman in America in need of a mastectomy and certain other procedures related to breast cancer will have access to such care and, with her doctor's consent, will be allowed to stay in the hospital for up to 48 hours after that operation has been conducted. This is an important protection for every woman in America; and as Congressman PALLONE said, while it is allowed in some States, it's not allowed in other States.

One of the things in this bill that I want to speak briefly about, Mr. Speaker, is that for the first time we put into Federal law a provision that says if an individual has a policy that's not a group policy but an individual policy and that individual has to have a procedure and the insurer, in looking into the primary procedure, discovers that there was some inadvertent omission of information on the person's health record that's not directly related to the procedure in question, then that person's health insurance coverage cannot be canceled.

□ 1930

I had a situation in my district, Mr. Speaker, within the last several months where a woman had decided to move out of State to take care of her parents. And when she did that, she lost her group coverage and she converted her group plan to a private insurance plan.

She moved, took care of her family, came back to Texas, and in a routine examination discovered that she had breast cancer. Her doctor recommended an immediate mastectomy. And when they went to schedule that, the insurance coverer began to go through her insurance application with a fine tooth comb and finally canceled it based on the proposition that she had failed to inform, in her private application, the fact that several years before she had been treated briefly for hypertension and taken some blood pressure medicine. She was no longer being treated and was no longer under medicine, but the fact that she failed to state on her original application that she had been in the past, the insurance carrier canceled her policy.

Now this is a woman who has been diagnosed with breast cancer. As we all know, if the treatment option that is recommended by the doctor is a mastectomy, that should be done as quickly as possible, yet this insurance carrier looked for a reason and finally found a reason and canceled her policy. Under the bill before us, Mr. Speaker, that would no longer be possible. The coverage would continue in force. And if it was discovered that there was an intentional fraudulent omission, then the coverage could be canceled; but if that's not the case, if it's truly inadvertent, it's not directly related, then you cannot cancel the insurance policy.

This bill and this amendment, if the other body passes it and it becomes law, literally can save tens of thousands of women's lives every year in America. So I am very honored to have played a small part in bringing this bill to the floor. And I am extremely pleased that the members of the Energy and Commerce Committee, on a bipartisan basis, included my amendment that I have just spoken about.

I urge this passage in the strongest possible terms. I thank my friend, Dr. BURGESS from Texas, for yielding me time.

Mr. PALLONE. Mr. Speaker, I am very proud now to yield 5 minutes to the sponsor of the legislation, the gentlewoman from Connecticut (Ms. DELAURO), who really has worked for so many years championing this cause.

Ms. DELAURO. I thank the gentleman from New Jersey.

After too many long years, this is a historic moment. After too many lost opportunities, this is our chance to make a difference and to take an important step toward meeting our commitment to the women of America.

I want to thank my colleague, Chairman DINGELL, with whom I introduced the very first version of the Breast Cancer Patient Protection Act over a decade ago. It is his partnership and that of our colleagues, Chairmen PALLONE, STARK, ANDREWS, MILLER, that helped to make this day and this vote possible.

I want to say thank you to the ranking member of the full committee, Mr. BARTON, for his support, and for the bipartisan support of this effort.

More than 12 years ago, I first met Dr. Kristen Zarfos. She walked into my office in Connecticut and told me that HMOs were forcing her to discharge her patients before they were ready, sometimes just hours after mastectomy surgery. Dr. Zarfos' experience inspired me to get involved. Her tireless work with patients in my State of Connecticut and with a network of doctors she knew around the country gathered support for this bill from the grass roots all the way to the Congress.

Today, a woman's chance of developing breast cancer in her lifetime is one in eight. Almost everyone knows someone who has suffered from this disease. If you have watched a loved one fighting for her life, you understand how important it is to have not only the loving support of family as I did during my fight against ovarian cancer, but also adequate recovery time in the hospital after surgery so you have the professional care to begin healing and to avoid infection.

A mastectomy is not an easy surgery; it is physically and emotionally traumatic. That is what the Breast Cancer Patient Protection bill is all about. It says that when it comes to mastectomies and lumpectomies, adequate recovery time in the hospital should not be negotiable. The last thing any woman should be doing at that time is fighting with her insurance company.

This bill does not mandate a 48-hour hospital stay if a patient chooses to go home sooner, nor does it set 48 hours as a maximum amount of time a woman can stay in the hospital. It simply ensures that any decision in favor of a shorter or longer hospital stay will be made by the patient and her doctor, and not an insurance company. It would also ensure women have access to second opinions and adequate hospital stays after having a lumpectomy.

Some may argue that the time for a bill like this has already passed, that States are beginning to address the issue, but the truth is that drive-through mastectomies continue to today.

At the Energy and Commerce Subcommittee hearing this spring—and I thank, again, the gentleman from New Jersey (Mr. PALLONE)—breast cancer patient Alva Williams testified that she had a mastectomy on March 6, 2006 and was sent home several hours after surgery. Her insurance company would not cover an overnight stay. Ms. Williams had family to take care of her at home, but they had no medical training. She developed an infection in her incisions. Recovering from the infection caused Ms. Williams' chemotherapy treatments to be delayed by 6 weeks.

All across the Nation women continue to suffer the same way that Alva Williams suffered, physically and emotionally, and yet without the care they should rightfully be getting for the insurance premiums that they have paid. And all across this Nation people everywhere are saying, ''No more.''

Twenty-three million Americans have signed Lifetime Television's petition calling for the Breast Cancer Patient Protection Act's passage. Now with 222 cosponsors in the House and Senators SNOWE and LANDRIEU leading 19 cosponsors in the Senate, strong bipartisan support exists for these most basic patient protections.

I urge my colleagues to support the Breast Cancer Patient Protection Act. Make this day a powerful turning point. We have a tremendous opportunity today to make it clear to women, to cancer patients, and to their families that we value your health.

I again thank my colleagues, and urge the support of this bill.

Mr. BURGESS. Mr. Speaker, this is an important bill. It raises a fundamental question, who should make a medical decision? Is it the insurance company? Is it the HMO? Is it the United States Congress? Or is it a Federal agency? The answer to that question is ''none of the above,'' it is the patient's physician, in consultation with the patient and her family. And this rightfully puts the decision back where it should have been all the time. Patient, in consultation with physician or family, should make the appropriate decision.

There is nothing in this bill that says a 48-hour stay is required or mandated. There is nothing in this bill that says a 48-hour stay is a maximum length of time.

I also want to thank the ranking member, Mr. BARTON, of the full committee for bringing the important amendment that would disallow an insurance company for rejecting an patient's claim based on an inadvertent error in the application process. This amounts to a clerical error that might seriously jeopardize a patient's health or leave a patient who was not expecting a very large medical expenditure to suddenly be facing one. And certainly, given the status of today's economic climate, that would be an intolerable occurrence as well.

I thank the author of the bill for bringing it forward. I thank the subcommittee chairman for bringing it to the floor.

Mr. Speaker, I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Thank you, Mr. PALLONE, and to the other side of the aisle, for bringing this wonderful bill before us, H.R. 758, the Breast Cancer Patient Protection Act.

Breast cancer is the second leading cause of cancer death among women and the leading cause of cancer death among women under the age of 40.

Marin County, in my district, just north of the Golden Gate Bridge in San Francisco, has the highest rate of breast cancer in the United States of America. Marin's rates are approximately 40 percent higher than national average, and about 30 percent higher than the rest of the Bay Area.

My constituents are personally involved in our need to increase the funding for research so that we can learn more about what is causing breast cancer and how best to treat it.

We must also pass H.R. 758, the Breast Cancer Patient Protection Act, so that we can ensure that doctors are the ones making the decisions about medical care, not health insurance companies, not clerks.

This bill, H.R. 758, will prohibit drive-through mastectomies. It will ensure that women receive the best possible care. The last thing a patient and her family needs to be dealing with when trying to fight breast cancer is battling with a health insurance company, battling about covering necessary medical treatment.

Again, Mr. Speaker, I urge my colleagues to support H.R. 758, the Breast Cancer Patient Protection Act, to leave the decisions about the medical care of breast cancer patients to doctors and their patients, not health insurance companies.

Mr. PALLONE. Mr. Speaker, I yield myself such time to close very briefly.

I cannot stress enough how important this legislation is. We obviously need to put an end to the drive-through mastectomy. And although it may be the case that they have been eliminated in a number of States, they have not been nationally. I would urge my colleagues to support this legislation.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I speak today on an important bill that I believe in, H.R. 758, The Breast Cancer Patient Protect Action of 2007. This bill is important to people facing this horrible disease, and it is time that we protect those who are the most vulnerable among us.

Patients who have breast cancer face a very tough road ahead. The medical realities are enough to frighten anyone and these patients face financial realities as well. With an ever corporatizing of the American health care system, it's more of an in and out process. Even those with excellent healthcare are pushed out of hospitals with great speed. Worse yet, those who do survive face an uphill battle making sure they can get the follow up they need to assure a long and healthy life.

This bill will show support for those with breast cancer that they are not alone. Worried

that while they are recovering from major surgery, their insurance company will look at the bottom line, and no longer pay for hospital stays. This bill will require insurance companies to pay for the stays as long as the doctor thinks is necessary. As I am sure all of my colleagues know, you cannot get an insurance company to do anything without regulation.

This legislation will also remove the doctor's biggest challenge, needing insurer's permission before doing what they believe is medically necessary. There is nothing worse about our healthcare system today then the thought that it's not your doctor making the decisions for your care, but it's the insurance company that pays him or her. It's an unfortunate reality that doctors must choose between caring for their patients and keeping their practice and families afloat. This bill will at least give these doctors back the right to have the option of always putting their patients first.

Last, this bill also provides for secondary consultations by specialists in the appropriate medical fields to confirm or refute a diagnosis of cancer. While the vast majority of cancer diagnoses are correct, with the small numbers that are ''false positives'' this bill will allow for patients to double check their status before undergoing very expensive and dangerous treatment.

I am reminded of the American political commentator, journalist, and author, Molly Ivins of Texas. Diagnosed with breast cancer when she was 55, she didn't look down on her situation and feel sorry for herself. She instead looked at it as an opportunity saying, ''One of the things I said was that I had been in great hopes I would become a better person as a result of confronting my own mortality, but it actually never happened. I didn't become a better person.'' After two mastectomies, Molly toured around the country speaking out about breast cancer awareness, tragically she later died of the disease.

Almost everyone has had, or knows someone who has breast cancer, it's our mothers and daughters, sisters and friends who face this disease, and it's time we honor them, by protecing those who come after them. I also pay tribute to the work of Sister's Network in supporting this bill.

Mr. Speaker, we need to make sure that doctors are making the right diagnosis, that they are making the choices in care and not the insurance companies and that the health and care of these patients are in the right hands. I urge passage of this bill.

Mr. LARSON of Connecticut. Mr. Speaker, I rise today in strong support of H.R. 758: the ''Breast Care Patient Protection Act of 2008.'' I would like to commend my colleague, Congresswoman ROSA DELAURO who has fought passionately for issues like these since she entered the Congress.

Put simply, this bill protects the health of women and ensures they have the time they need to recover from difficult medical procedures. With passage of this legislation no longer will women have to feel pushed out the door following breast cancer treatment. There are too many stories of women across the country who ave suffered from not being given the proper time to recover from breast cancer surgery for Congress to stand idle.

According to the Connecticut Department of Health, in 2004, 29 percent of all new diagnosed cases of cancer in Connecticut were breast cancer. This was more than any other type of cancer diagnosed in women in the State.

While we need to continue to be vigilant in the fight against the causes of breast cancer we must also ensure that those seeking treatment are given the protections to allow for them to properly recover. I again commend my colleague Ms. DELAURO and repeat my firm support of this legislation.

Ms. SLAUGHTER. Mr. Speaker, today I rise in support of the Breast Cancer Patient Protection Act and urge its passage.

Breast cancer is so pervasive it touches every American family. One in eight women can expect to be diagnosed with breast cancer during her lifetime, and it remains the number one cause of death in women between the ages of 30 and 54. In my congressional district there are almost 1,500 incidences of breast cancer and nearly 300 women die ftom this disease every year.

Breast cancer surgery is not easy, physically or emotionally—but all too often women find themselves forced by their insurance companies to leave the hospital before they are ready—sometimes just hours after surgery.

One woman ftom New York said: ''I was one of those women that was forced out of the hospital after having a double bilateral mastectomy with four drainage tubes still attached. It was the most barbaric thing ever done to me.''

Rushing a woman through a hospital stay and pressuring her to return to her normal life almost immediately, hampers her recovery at the least and may put her in grave danger. That is why it is imperative that we pass the Breast Cancer Patient Protection Act.

This bill would help ensure that patients have adequate support after breast cancer surgery by: Guaranteeing a minimum hospital stay of 48 hours for a woman having a mastectomy or lumpectomy, and 24 hours for a woman undergoing a lymph node removal; requiring health plans to include notice of these benefits in their monthly mailing and yearly information packet sent to plan participants; and requiring plans to cover a second opinion should the patient seek one.

We must also support research into better breast cancer detection methods. Mammographies miss too many women and cannot suffice as our gold standard.

Women diagnosed with breast cancer across this country deserve the best care possible—their lives depend on it.

Mr. VANHOLLEN. Mr. Speaker, I rise in strong support of the Breast Cancer Patient Protection Act of 2008.

Over two million women living in this country have been treated for breast cancer. This common sense legislation would allow a woman and her doctor to decide—rather than the insurance company—whether she needs to have adequate time of at least 48 hours to recuperate in the hospital from a mastectomy or lumpectomy, or whether she has enough support to get quality care at home. As someone who has lost their mother to breast cancer, the last thing women undergoing these invasive procedures should have to deal with is fight with their insurance company.

Mr. Speaker, I urge my colleagues to support this compassionate bill. It will ensure that women suffering from this terrible disease have access to appropriate health care.

Mr. PALLONE. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 758, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. PALLONE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

HEALTH INSURANCE RESTRICTIONS AND LIMITATIONS CLARIFICATION ACT OF 2008

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6908) to require that limitations and restrictions on coverage under group health plans be timely disclosed to group health plan sponsors and timely communicated to participants and beneficiaries under such plans in a form that is easily understandable, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6908

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 ''Health Insurance Restrictions and Limitations Clarification Act of 2008''.

SEC. 2. DISCLOSURE REQUIREMENTS.

(a) ERISA.—Section 702(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(2)(B)) is amended by inserting before the period at the end the following: ''so long as—

''(i) such limitations and restrictions are explicit and clear;

''(ii) in the case of such limitations and restrictions in health insurance coverage offered in connection with the group health plan, such limitations and restrictions have been disclosed in writing to the plan sponsor in advance of the point of sale to the plan;

''(iii) the plan sponsor of the health insurance coverage provide, to participants and beneficiaries in the plan in advance of the point of their enrollment under the plan, a description of such limitations and restrictions in a form that is easily understandable by such participants and beneficiaries; and

''(iv) the plan sponsor and the issuer of the coverage provide such description to participants and beneficiaries upon their enrollment under the plan at the earliest opportunity that other materials are provided''.

(b) PHSA.—Section 2702(a)(2)(B) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(2)(B)) is amended by inserting before the period at the end the following: ''so long as—

''(i) such limitations and restrictions are explicit and clear;

''(ii) in the case of such limitations and restrictions in health insurance coverage offered in connection with the group health plan, such limitations and restrictions have been disclosed in writing to the plan sponsor in advance of the point of sale to the plan;

''(iii) the plan sponsor and the issuer of the group health insurance coverage make available, to participants and beneficiaries in the