

107TH CONGRESS
1ST SESSION

H. R. 1809

To amend the Employee Retirement Income Security Act of 1974, Public Health Service Act, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage of cancer screening.

IN THE HOUSE OF REPRESENTATIVES

MAY 10, 2001

Mrs. MALONEY of New York (for herself, Mrs. KELLY, Mr. RANGEL, Mr. GILMAN, Mr. BONIOR, Mr. QUINN, Mr. FROST, Mr. SMITH of New Jersey, Ms. PELOSI, Mrs. MORELLA, Mr. TOWNS, Mr. WYNN, Mr. OBERSTAR, Mrs. MINK of Hawaii, Ms. WOOLSEY, Mr. BALDACCI, Mr. GONZALEZ, Mr. LANGEVIN, Mrs. THURMAN, Ms. MILLENDER-McDONALD, Mr. HASTINGS of Florida, Ms. LEE, Mr. HILLIARD, Mr. LEWIS of Georgia, Mr. LANTOS, Mr. CUMMINGS, Mr. WEXLER, Ms. JACKSON-LEE of Texas, Mrs. TAUSCHER, Mr. CAPUANO, Ms. HARMAN, Mr. MEEKS of New York, and Mr. KILDEE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Ways and Means, and Government Reform, 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 amend the Employee Retirement Income Security Act of 1974, Public Health Service Act, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage of cancer screening.

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 “Cancer Screening Cov-
5 erage Act of 2001”.

6 **SEC. 2. CANCER SCREENING COVERAGE.**

7 (a) GROUP HEALTH PLANS.—

8 (1) PUBLIC HEALTH SERVICE ACT AMEND-
9 MENTS.—

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

14 **“SEC. 2707. COVERAGE OF CANCER SCREENING.**

15 “(a) REQUIREMENT.—A group health plan, and a
16 health insurance issuer offering group health insurance
17 coverage, shall provide coverage and payment under the
18 plan or coverage for the following items and services under
19 terms and conditions that are no less favorable than the
20 terms and conditions applicable to other screening benefits
21 otherwise provided under the plan or coverage:

22 “(1) MAMMOGRAMS.—In the case of a female
23 participant or beneficiary who is 40 years of age or
24 older, or is under 40 years of age but is at high risk
25 (as defined in subsection (e)) of developing breast

1 cancer, an annual mammography (as defined in sec-
2 tion 1861(jj) of the Social Security Act) conducted
3 by a facility that has a certificate (or provisional cer-
4 tificate) issued under section 354.

5 “(2) CLINICAL BREAST EXAMINATIONS.—In the
6 case of a female participant or beneficiary who—

7 “(A)(i) is 40 years of age or older or (ii)
8 is at least 20 (but less than 40) years of age
9 and is at high risk of developing breast cancer,
10 an annual clinical breast examination; or

11 “(B) is at least 20, but less than 40, years
12 of age and who is not at high risk of developing
13 breast cancer, a clinical breast examination
14 each 3 years.

15 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
16 In the case of a female participant or beneficiary
17 who is 18 years of age or older, or who is under 18
18 years of age and is or has been sexually active—

19 “(A) an annual diagnostic laboratory test
20 (popularly known as a ‘pap smear’) consisting
21 of a routine exfoliative cytology test (Papani-
22 colaou test) provided to a woman for the pur-
23 pose of early detection of cervical or vaginal
24 cancer and including an interpretation by a

1 qualified health professional of the results of
2 the test; and

3 “(B) an annual pelvic examination.

4 “(4) COLORECTAL CANCER SCREENING PROCE-
5 DURES.—In the case of a participant or beneficiary
6 who is 50 years of age or older, or who is under 50
7 years of age and is at high risk of developing
8 colorectal cancer, the procedures described in section
9 1861(pp)(1) of the Social Security Act (42 U.S.C.
10 1395x(pp)(1)) or section 4104(a)(2) of the Balanced
11 Budget Act of 1997 (111 Stat. 362), shall be fur-
12 nished to the individual for the purpose of early de-
13 tection of colorectal cancer. The group health plan
14 or health insurance issuer shall provide coverage for
15 the method and frequency of colorectal cancer
16 screening determined to be appropriate by a health
17 care provider treating such participant or bene-
18 ficiary, in consultation with the participant or bene-
19 ficiary.

20 “(5) PROSTATE CANCER SCREENING.—In the
21 case of a male participant or beneficiary who is 50
22 years of age or older, or who is younger than 50
23 years of age and is at high risk for prostate cancer
24 (including African American men or a male who has
25 a history of prostate cancer in 1 or more first degree

1 family members), the procedures described in section
2 1861(oo)(2) of Social Security Act (42 U.S.C.
3 1395x(oo)(2)) shall be furnished to the individual
4 for the early detection of prostate cancer. The group
5 health plan or health insurance issuer shall provide
6 coverage for the method and frequency of prostate
7 cancer screening determined to be appropriate by a
8 health care provider treating such participant or
9 beneficiary, in consultation with the participant or
10 beneficiary.

11 “(6) OTHER TESTS AND PROCEDURES.—Such
12 other tests or procedures for the detection of cancer,
13 and modifications to the tests and procedures, with
14 such frequency, as the Secretary determines to be
15 appropriate, in consultation with appropriate organi-
16 zations and agencies, for the diagnosis or detection
17 of cancer.

18 “(b) PROHIBITIONS.—A group health plan, and a
19 health insurance issuer offering group health insurance
20 coverage in connection with a group health plan, shall
21 not—

22 “(1) deny to an individual eligibility, or contin-
23 ued eligibility, to enroll or to renew coverage under
24 the terms of the plan, solely for the purpose of
25 avoiding the requirements of this section;

1 “(2) provide monetary payments or rebates to
2 individuals to encourage such individuals to accept
3 less than the minimum protections available under
4 this section;

5 “(3) penalize or otherwise reduce or limit the
6 reimbursement of a provider because such provider
7 provided care to an individual participant or bene-
8 ficiary in accordance with this section; or

9 “(4) provide incentives (monetary or otherwise)
10 to a provider to induce such provider to provide care
11 to an individual participant or beneficiary in a man-
12 ner inconsistent with this section.

13 “(c) RULES OF CONSTRUCTION.—

14 “(1) Nothing in this section shall be construed
15 to require an individual who is a participant or bene-
16 ficiary to undergo a procedure, examination, or test
17 described in subsection (a).

18 “(2) Nothing in this section shall be construed
19 as preventing a group health plan or issuer from im-
20 posing deductibles, coinsurance, or other cost-shar-
21 ing in relation to benefits described in subsection (a)
22 consistent with such subsection, except that such co-
23 insurance or other cost-sharing shall not discrimi-
24 nate on any basis related to the coverage required
25 under this section.

1 “(d) NOTICE.—A group health plan under this part
2 shall comply with the notice requirement under section
3 714(d) of the Employee Retirement Income Security Act
4 of 1974 with respect to the requirements of this section
5 as if such section applied to such plan.

6 “(e) HIGH RISK DEFINED.—For purposes of this
7 section, an individual is considered to be at ‘high risk’ of
8 developing a particular type of cancer if, under guidelines
9 developed or recognized by the Secretary based upon sci-
10 entific evidence, the individual—

11 “(1) has 1 or more first degree family members
12 who have developed that type of cancer;

13 “(2) has previously had that type of cancer;

14 “(3) has the presence of an appropriate recog-
15 nized gene marker that is identified as putting the
16 individual at a higher risk of developing that type of
17 cancer; or

18 “(4) has other predisposing factors that signifi-
19 cantly increases the risk of the individual con-
20 tracting that type of cancer.

21 For purposes of this subsection, the term ‘type of cancer’
22 includes other types of cancer that the Secretary recog-
23 nizes as closely related for purposes of establishing risk.

1 **“SEC. 2708. PATIENT ACCESS TO INFORMATION.**

2 “(a) DISCLOSURE REQUIREMENT.—A group health
3 plan, and health insurance issuer offering group health in-
4 surance coverage shall—

5 “(1) provide to participants and beneficiaries at
6 the time of initial coverage under the plan (or the
7 effective date of this section, in the case of individ-
8 uals who are participants or beneficiaries as of such
9 date), and at least annually thereafter, the informa-
10 tion described in subsection (b) in printed form;

11 “(2) provide to participants and beneficiaries,
12 within a reasonable period (as specified by the ap-
13 propriate Secretary) before or after the date of sig-
14 nificant changes in the information described in sub-
15 section (b), information in printed form regarding
16 such significant changes; and

17 “(3) upon request, make available to partici-
18 pants and beneficiaries, the applicable authority, and
19 prospective participants and beneficiaries, the infor-
20 mation described in subsection (b) in printed form.

21 “(b) INFORMATION PROVIDED.—The information de-
22 scribed in subsection (a) that shall be disclosed includes
23 the following, as such relates to cancer screening required
24 under section 2707(a):

25 “(1) BENEFITS.—Benefits offered under the
26 plan or coverage, including—

1 “(A) covered benefits, including benefit
2 limits and coverage exclusions;

3 “(B) cost sharing, such as deductibles, co-
4 insurance, and copayment amounts, including
5 any liability for balance billing, any maximum
6 limitations on out of pocket expenses, and the
7 maximum out of pocket costs for services that
8 are provided by nonparticipating providers or
9 that are furnished without meeting the applica-
10 ble utilization review requirements;

11 “(C) the extent to which benefits may be
12 obtained from nonparticipating providers; and

13 “(D) the extent to which a participant,
14 beneficiary, or enrollee may select from among
15 participating providers and the types of pro-
16 viders participating in the plan or issuer net-
17 work.

18 “(2) ACCESS.—A description of the following:

19 “(A) The number, mix, and distribution of
20 providers under the plan or coverage.

21 “(B) Out-of-network coverage (if any) pro-
22 vided by the plan or coverage.

23 “(C) Any point-of-service option (including
24 any supplemental premium or cost-sharing for
25 such option).

1 “(D) The procedures for participants,
2 beneficiaries, and enrollees to select, access, and
3 change participating primary and specialty pro-
4 viders.

5 “(E) The rights and procedures for obtain-
6 ing referrals (including standing referrals) to
7 participating and nonparticipating providers.

8 “(F) The name, address, and telephone
9 number of participating health care providers
10 and an indication of whether each such provider
11 is available to accept new patients.

12 “(G) How the plan or issuer addresses the
13 needs of participants, beneficiaries, and enroll-
14 ees and others who do not speak English or
15 who have other special communications needs in
16 accessing providers under the plan or coverage,
17 including the provision of information under
18 this subsection.”.

19 (B) TECHNICAL AMENDMENT.—Section
20 2723(c) of the Public Health Service Act (42
21 U.S.C. 300gg–23(c)) is amended by striking
22 “section 2704” and inserting “sections 2704
23 and 2707”.

24 (2) ERISA AMENDMENTS.—

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

6 **“SEC. 714. COVERAGE OF CANCER SCREENING.**

7 “(a) REQUIREMENT.—A group health plan, and a
8 health insurance issuer offering group health insurance
9 coverage, shall provide coverage and payment under the
10 plan or coverage for the following items and services under
11 terms and conditions that are no less favorable than the
12 terms and conditions applicable to other screening benefits
13 otherwise provided under the plan or coverage:

14 “(1) MAMMOGRAMS.—In the case of a female
15 participant or beneficiary who is 40 years of age or
16 older, or is under 40 years of age but is at high risk
17 (as defined in subsection (e)) of developing breast
18 cancer, an annual mammography (as defined in sec-
19 tion 1861(jj) of the Social Security Act) conducted
20 by a facility that has a certificate (or provisional cer-
21 tificate) issued under section 354 of the Public
22 Health Service Act.

23 “(2) CLINICAL BREAST EXAMINATIONS.—In the
24 case of a female participant or beneficiary who—

1 “(A)(i) is 40 years of age or older or (ii)
2 is at least 20 (but less than 40) years of age
3 and is at high risk of developing breast cancer,
4 an annual clinical breast examination; or

5 “(B) is at least 20, but less than 40, years
6 of age and who is not at high risk of developing
7 breast cancer, a clinical breast examination
8 each 3 years.

9 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
10 In the case of a female participant or beneficiary
11 who is 18 years of age or older, or who is under 18
12 years of age and is or has been sexually active—

13 “(A) an annual diagnostic laboratory test
14 (popularly known as a ‘pap smear’) consisting
15 of a routine exfoliative cytology test (Papani-
16 colaou test) provided to a woman for the pur-
17 pose of early detection of cervical or vaginal
18 cancer and including an interpretation by a
19 qualified health professional of the results of
20 the test; and

21 “(B) an annual pelvic examination.

22 “(4) COLORECTAL CANCER SCREENING PROCE-
23 DURES.—In the case of a participant or beneficiary
24 who is 50 years of age or older, or who is under 50
25 years of age and is at high risk of developing

1 colorectal cancer, the procedures described in section
2 1861(pp)(1) of the Social Security Act (42 U.S.C.
3 1395x(pp)(1)) or section 4104(a)(2) of the Balanced
4 Budget Act of 1997 (111 Stat. 362), shall be fur-
5 nished to the individual for the purpose of early de-
6 tection of colorectal cancer. The group health plan
7 or health insurance issuer shall provided coverage
8 for the method and frequency of colorectal cancer
9 screening determined to be appropriate by a health
10 care provider treating such participant or bene-
11 ficiary, in consultation with the participant or bene-
12 ficiary.

13 “(5) PROSTATE CANCER SCREENING.—In the
14 case of a male participant or beneficiary who is 50
15 years of age or older, or who is younger than 50
16 years of age and is at high risk for prostate cancer
17 (including African American men or a male who has
18 a history of prostate cancer in 1 or more first degree
19 family members), the procedures described in section
20 1861(oo)(2) of Social Security Act (42 U.S.C.
21 1395x(oo)(2)) shall be furnished to the individual
22 for the early detection of prostate cancer. The group
23 health plan or health insurance issuer shall provide
24 coverage for the method and frequency of prostate
25 cancer screening determined to be appropriate by a

1 health care provider treating such participant or
2 beneficiary, in consultation with the participant or
3 beneficiary.

4 “(6) OTHER TESTS AND PROCEDURES.—Such
5 other tests or procedures for the detection of cancer,
6 and modifications to the tests and procedures, with
7 such frequency, as the Secretary determines to be
8 appropriate, in consultation with appropriate organi-
9 zations and agencies, for the diagnosis or detection
10 of cancer.

11 “(b) PROHIBITIONS.—A group health plan, and a
12 health insurance issuer offering group health insurance
13 coverage in connection with a group health plan, may
14 not—

15 “(1) deny to an individual eligibility, or contin-
16 ued eligibility, to enroll or to renew coverage under
17 the terms of the plan, solely for the purpose of
18 avoiding the requirements of this section;

19 “(2) provide monetary payments or rebates to
20 individuals to encourage such individuals to accept
21 less than the minimum protections available under
22 this section;

23 “(3) penalize or otherwise reduce or limit the
24 reimbursement of a provider because such provider

1 provided care to an individual participant or bene-
2 ficiary in accordance with this section; or

3 “(4) provide incentives (monetary or otherwise)
4 to a provider to induce such provider to provide care
5 to an individual participant or beneficiary in a man-
6 ner inconsistent with this section.

7 “(c) RULES OF CONSTRUCTION.—

8 “(1) Nothing in this section shall be construed
9 to require an individual who is a participant or bene-
10 ficiary to undergo a procedure, examination, or test
11 described in subsection (a).

12 “(2) Nothing in this section shall be construed
13 as preventing a group health plan or issuer from im-
14 posing deductibles, coinsurance, or other cost-shar-
15 ing in relation to benefits described in subsection (a)
16 consistent with such subsection, except that such co-
17 insurance or other cost-sharing shall not discrimi-
18 nate on any basis related to the coverage required
19 under this section.

20 “(d) NOTICE UNDER GROUP HEALTH PLAN.—The
21 imposition of the requirement of this section shall be treat-
22 ed as a material modification in the terms of the plan de-
23 scribed in section 102(a), for purposes of assuring notice
24 of such requirements under the plan; except that the sum-
25 mary description required to be provided under the last

1 sentence of section 104(b)(1) with respect to such modi-
2 fication shall be provided by not later than 60 days after
3 the first day of the first plan year in which such require-
4 ment apply.

5 “(e) HIGH RISK DEFINED.—For purposes of this
6 section, an individual is considered to be at ‘high risk’ of
7 developing a particular type of cancer if, under guidelines
8 developed or recognized by the Secretary based upon sci-
9 entific evidence, the individual—

10 “(1) has 1 or more first degree family members
11 who have developed that type of cancer;

12 “(2) has previously had that type of cancer;

13 “(3) has the presence of an appropriate recog-
14 nized gene marker that is identified as putting the
15 individual at a higher risk of developing that type of
16 cancer; or

17 “(4) has other predisposing factors that signifi-
18 cantly increases the risk of the individual con-
19 tracting that type of cancer.

20 For purposes of this subsection, the term ‘type of cancer’
21 includes other types of cancer that the Secretary recog-
22 nizes as closely related for purposes of establishing risk.

1 **“SEC. 715. PATIENT ACCESS TO INFORMATION.**

2 “(a) DISCLOSURE REQUIREMENT.—A group health
3 plan, and health insurance issuer offering group health in-
4 surance coverage shall—

5 “(1) provide to participants and beneficiaries at
6 the time of initial coverage under the plan (or the
7 effective date of this section, in the case of individ-
8 uals who are participants or beneficiaries as of such
9 date), and at least annually thereafter, the informa-
10 tion described in subsection (b) in printed form;

11 “(2) provide to participants and beneficiaries,
12 within a reasonable period (as specified by the ap-
13 propriate Secretary) before or after the date of sig-
14 nificant changes in the information described in sub-
15 section (b), information in printed form regarding
16 such significant changes; and

17 “(3) upon request, make available to partici-
18 pants and beneficiaries, the applicable authority, and
19 prospective participants and beneficiaries, the infor-
20 mation described in subsection (b) in printed form.

21 “(b) INFORMATION PROVIDED.—The information de-
22 scribed in subsection (a) that shall be disclosed includes
23 the following, as such relates to cancer screening required
24 under section 714(a):

25 “(1) BENEFITS.—Benefits offered under the
26 plan or coverage, including—

1 “(A) covered benefits, including benefit
2 limits and coverage exclusions;

3 “(B) cost sharing, such as deductibles, co-
4 insurance, and copayment amounts, including
5 any liability for balance billing, any maximum
6 limitations on out of pocket expenses, and the
7 maximum out of pocket costs for services that
8 are provided by nonparticipating providers or
9 that are furnished without meeting the applica-
10 ble utilization review requirements;

11 “(C) the extent to which benefits may be
12 obtained from nonparticipating providers; and

13 “(D) the extent to which a participant,
14 beneficiary, or enrollee may select from among
15 participating providers and the types of pro-
16 viders participating in the plan or issuer net-
17 work.

18 “(2) ACCESS.—A description of the following:

19 “(A) The number, mix, and distribution of
20 providers under the plan or coverage.

21 “(B) Out-of-network coverage (if any) pro-
22 vided by the plan or coverage.

23 “(C) Any point-of-service option (including
24 any supplemental premium or cost-sharing for
25 such option).

1 “(D) The procedures for participants,
2 beneficiaries, and enrollees to select, access, and
3 change participating primary and specialty pro-
4 viders.

5 “(E) The rights and procedures for obtain-
6 ing referrals (including standing referrals) to
7 participating and nonparticipating providers.

8 “(F) The name, address, and telephone
9 number of participating health care providers
10 and an indication of whether each such provider
11 is available to accept new patients.

12 “(G) How the plan or issuer addresses the
13 needs of participants, beneficiaries, and enroll-
14 ees and others who do not speak English or
15 who have other special communications needs in
16 accessing providers under the plan or coverage,
17 including the provision of information under
18 this subsection.”.

19 (B) TECHNICAL AMENDMENTS.—

20 (i) Section 731(c) of the Employee
21 Retirement Income Security Act of 1974
22 (29 U.S.C. 1191(c)) is amended by strik-
23 ing “section 711” and inserting “sections
24 711 and 714”.

1 (ii) Section 732(a) of the Employee
 2 Retirement Income Security Act of 1974
 3 (29 U.S.C. 1191a(a)) is amended by strik-
 4 ing “section 711” and inserting “sections
 5 711 and 714”.

6 (iii) The table of contents in section 1
 7 of the Employee Retirement Income Secu-
 8 rity Act of 1974 is amended by inserting
 9 after the item relating to section 713 the
 10 following new items:

“Sec. 714. Coverage of cancer screening.”.

“Sec. 715. Patient access to information.”.

11 (3) INTERNAL REVENUE CODE AMEND-
 12 MENTS.—Subchapter B of chapter 100 of the Inter-
 13 nal Revenue Code of 1986 is amended—

14 (A) in the table of sections, by inserting
 15 after the item relating to section 9812 the fol-
 16 lowing new items:

“Sec. 9813. Coverage of cancer screening.

“Sec. 9814. Patient access to information.”;

17 and

18 (B) by inserting after section 9812 the fol-
 19 lowing:

20 **“SEC. 9813. COVERAGE OF CANCER SCREENING.**

21 “(a) REQUIREMENT.—A group health plan shall pro-
 22 vide coverage and payment under the plan for the fol-
 23 lowing items and services under terms and conditions that

1 are no less favorable than the terms and conditions appli-
2 cable to other screening benefits otherwise provided under
3 the plan:

4 “(1) MAMMOGRAMS.—In the case of a female
5 participant or beneficiary who is 40 years of age or
6 older, or is under 40 years of age but is at high risk
7 (as defined in subsection (d)) of developing breast
8 cancer, an annual mammography (as defined in sec-
9 tion 1861(jj) of the Social Security Act) conducted
10 by a facility that has a certificate (or provisional cer-
11 tificate) issued under section 354 of the Public
12 Health Service Act.

13 “(2) CLINICAL BREAST EXAMINATIONS.—In the
14 case of a female participant or beneficiary who—

15 “(A)(i) is 40 years of age or older or (ii)
16 is at least 20 (but less than 40) years of age
17 and is at high risk of developing breast cancer,
18 an annual clinical breast examination; or

19 “(B) is at least 20, but less than 40, years
20 of age and who is not at high risk of developing
21 breast cancer, a clinical breast examination
22 each 3 years.

23 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
24 In the case of a female participant or beneficiary

1 who is 18 years of age or older, or who is under 18
2 years of age and is or has been sexually active—

3 “(A) an annual diagnostic laboratory test
4 (popularly known as a ‘pap smear’) consisting
5 of a routine exfoliative cytology test (Papani-
6 colaou test) provided to a woman for the pur-
7 pose of early detection of cervical or vaginal
8 cancer and including an interpretation by a
9 qualified health professional of the results of
10 the test; and

11 “(B) an annual pelvic examination.

12 “(4) COLORECTAL CANCER SCREENING PROCE-
13 DURES.—In the case of a participant or beneficiary
14 who is 50 years of age or older, or who is under 50
15 years of age and is at high risk of developing
16 colorectal cancer, the procedures described in section
17 1861(pp)(1) of the Social Security Act (42 U.S.C.
18 1395x(pp)(1)) or section 4104(a)(2) of the Balanced
19 Budget Act of 1997 (111 Stat. 362), shall be fur-
20 nished to the individual for the purpose of early de-
21 tection of colorectal cancer. The group health plan
22 or health insurance issuer shall provide coverage for
23 the method and frequency of colorectal cancer
24 screening determined to be appropriate by a health
25 care provider treating such participant or bene-

1 ficiary, in consultation with the participant or bene-
2 ficiary.

3 “(5) PROSTATE CANCER SCREENING.—In the
4 case of a male participant or beneficiary who is 50
5 years of age or older, or who is younger than 50
6 years of age and is at high risk for prostate cancer
7 (including African American men or a male who has
8 a history of prostate cancer in 1 or more first degree
9 family members), the procedures described in section
10 1861(oo)(2) of Social Security Act (42 U.S.C.
11 1395x(oo)(2)) shall be furnished to the individual
12 for the early detection of prostate cancer. The group
13 health plan or health insurance issuer shall provide
14 coverage for the method and frequency of prostate
15 cancer screening determined to be appropriate by a
16 health care provider treating such participant or
17 beneficiary, in consultation with the participant or
18 beneficiary.

19 “(6) OTHER TESTS AND PROCEDURES.—Such
20 other tests or procedures for the detection of cancer,
21 and modifications to the tests and procedures, with
22 such frequency, as the Secretary determines to be
23 appropriate, in consultation with appropriate organi-
24 zations and agencies, for the diagnosis or detection
25 of cancer.

1 “(b) PROHIBITIONS.—A group health plan may not—

2 “(1) deny to an individual eligibility, or contin-
3 ued eligibility, to enroll or to renew coverage under
4 the terms of the plan, solely for the purpose of
5 avoiding the requirements of this section;

6 “(2) provide monetary payments or rebates to
7 individuals to encourage such individuals to accept
8 less than the minimum protections available under
9 this section;

10 “(3) penalize or otherwise reduce or limit the
11 reimbursement of a provider because such provider
12 provided care to an individual participant or bene-
13 ficiary in accordance with this section; or

14 “(4) provide incentives (monetary or otherwise)
15 to a provider to induce such provider to provide care
16 to an individual participant or beneficiary in a man-
17 ner inconsistent with this section.

18 “(c) RULES OF CONSTRUCTION.—

19 “(1) Nothing in this section shall be construed
20 to require an individual who is a participant or bene-
21 ficiary to undergo a procedure, examination, or test
22 described in subsection (a).

23 “(2) Nothing in this section shall be construed
24 as preventing a group health plan from imposing
25 deductibles, coinsurance, or other cost-sharing in re-

1 lation to benefits described in subsection (a) con-
2 sistent with such subsection, except that such coin-
3 surance or other cost-sharing shall not discriminate
4 on any basis related to the coverage required under
5 this section.

6 “(d) HIGH RISK DEFINED.—For purposes of this
7 section, an individual is considered to be at ‘high risk’ of
8 developing a particular type of cancer if, under guidelines
9 developed or recognized by the Secretary based upon sci-
10 entific evidence, the individual—

11 “(1) has 1 or more first degree family members
12 who have developed that type of cancer;

13 “(2) has previously had that type of cancer;

14 “(3) has the presence of an appropriate recog-
15 nized gene marker that is identified as putting the
16 individual at a higher risk of developing that type of
17 cancer; or

18 “(4) has other predisposing factors that signifi-
19 cantly increases the risk of the individual con-
20 tracting that type of cancer.

21 For purposes of this subsection, the term ‘type of cancer’
22 includes other types of cancer that the Secretary recog-
23 nizes as closely related for purposes of establishing risk.

1 **“SEC. 9814. PATIENT ACCESS TO INFORMATION.**

2 “(a) DISCLOSURE REQUIREMENT.—A group health
3 plan, and health insurance issuer offering group health in-
4 surance coverage shall—

5 “(1) provide to participants and beneficiaries at
6 the time of initial coverage under the plan (or the
7 effective date of this section, in the case of individ-
8 uals who are participants or beneficiaries as of such
9 date), and at least annually thereafter, the informa-
10 tion described in subsection (b) in printed form;

11 “(2) provide to participants and beneficiaries,
12 within a reasonable period (as specified by the ap-
13 propriate Secretary) before or after the date of sig-
14 nificant changes in the information described in sub-
15 section (b), information in printed form regarding
16 such significant changes; and

17 “(3) upon request, make available to partici-
18 pants and beneficiaries, the applicable authority, and
19 prospective participants and beneficiaries, the infor-
20 mation described in subsection (b) in printed form.

21 “(b) INFORMATION PROVIDED.—The information de-
22 scribed in subsection (a) that shall be disclosed includes
23 the following, as such relates to cancer screening required
24 under section 9813(a):

25 “(1) BENEFITS.—Benefits offered under the
26 plan or coverage, including—

1 “(A) covered benefits, including benefit
2 limits and coverage exclusions;

3 “(B) cost sharing, such as deductibles, co-
4 insurance, and copayment amounts, including
5 any liability for balance billing, any maximum
6 limitations on out of pocket expenses, and the
7 maximum out of pocket costs for services that
8 are provided by nonparticipating providers or
9 that are furnished without meeting the applica-
10 ble utilization review requirements;

11 “(C) the extent to which benefits may be
12 obtained from nonparticipating providers; and

13 “(D) the extent to which a participant,
14 beneficiary, or enrollee may select from among
15 participating providers and the types of pro-
16 viders participating in the plan or issuer net-
17 work.

18 “(2) ACCESS.—A description of the following:

19 “(A) The number, mix, and distribution of
20 providers under the plan or coverage.

21 “(B) Out-of-network coverage (if any) pro-
22 vided by the plan or coverage.

23 “(C) Any point-of-service option (including
24 any supplemental premium or cost-sharing for
25 such option).

1 “(D) The procedures for participants,
2 beneficiaries, and enrollees to select, access, and
3 change participating primary and specialty pro-
4 viders.

5 “(E) The rights and procedures for obtain-
6 ing referrals (including standing referrals) to
7 participating and nonparticipating providers.

8 “(F) The name, address, and telephone
9 number of participating health care providers
10 and an indication of whether each such provider
11 is available to accept new patients.

12 “(G) How the plan or issuer addresses the
13 needs of participants, beneficiaries, and enroll-
14 ees and others who do not speak English or
15 who have other special communications needs in
16 accessing providers under the plan or coverage,
17 including the provision of information under
18 this subsection.”.

19 (b) INDIVIDUAL HEALTH INSURANCE.—

20 (1) IN GENERAL.—Part B of title XXVII of the
21 Public Health Service Act is amended by inserting
22 after section 2752 (42 U.S.C. 300gg–52) the fol-
23 lowing new section:

1 **“SEC. 2753. STANDARD RELATING PATIENT FREEDOM OF**
2 **CHOICE.**

3 “(a) IN GENERAL.—The provisions of section 2707
4 (other than subsection (d)) shall apply to health insurance
5 coverage offered by a health insurance issuer in the indi-
6 vidual market with respect to an enrollee under such cov-
7 erage in the same manner as they apply to health insur-
8 ance coverage offered by a health insurance issuer in con-
9 nection with a group health plan in the small or large
10 group market to a participant or beneficiary in such plan.

11 “(b) NOTICE.—A health insurance issuer under this
12 part shall comply with the notice requirement under sec-
13 tion 714(d) of the Employee Retirement Income Security
14 Act of 1974 with respect to the requirements referred to
15 in subsection (a) as if such section applied to such issuer
16 and such issuer were a group health plan.

17 **“SEC. 2754. PATIENT ACCESS TO INFORMATION.**

18 “The provisions of section 2708 shall apply health in-
19 surance coverage offered by a health insurance issuer in
20 the individual market with respect to an enrollee under
21 such coverage in the same manner as they apply to health
22 insurance coverage offered by a health insurance issuer
23 in connection with a group health plan in the small or
24 large group market to a participant or beneficiary in such
25 plan.”.

1 (2) TECHNICAL AMENDMENT.—Section
2 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))
3 is amended by striking “section 2751” and inserting
4 “sections 2751 and 2753”.

5 (c) EFFECTIVE DATES.—

6 (1) GROUP HEALTH PLANS.—Subject to para-
7 graph (3), the amendments made by subsection (a)
8 shall apply with respect to group health plans for
9 plan years beginning on or after January 1, 2002.

10 (2) INDIVIDUAL PLANS.—The amendment made
11 by subsection (b) shall apply with respect to health
12 insurance coverage offered, sold, issued, renewed, in
13 effect, or operated in the individual market on or
14 after such date.

15 (3) COLLECTIVE BARGAINING AGREEMENT.—In
16 the case of a group health plan maintained pursuant
17 to 1 or more collective bargaining agreements be-
18 tween employee representatives and 1 or more em-
19 ployers ratified before the date of enactment of this
20 Act, the amendments made to subsection (a) shall
21 not apply to plan years beginning before the later
22 of—

23 (A) the date on which the last collective
24 bargaining agreements relating to the plan ter-
25 minates (determined without regard to any ex-

1 tension thereof agreed to after the date of en-
2 actment of this Act), or

3 (B) January 1, 2002.

4 For purposes of subparagraph (A), any plan amend-
5 ment made pursuant to a collective bargaining
6 agreement relating to the plan which amends the
7 plan solely to conform to any requirement added by
8 subsection (a) shall not be treated as a termination
9 of such collective bargaining agreement.

10 (d) COORDINATED REGULATIONS.—Section 104(1)
11 of Health Insurance Portability and Accountability Act of
12 1996 (Public Law 104–191) is amended by striking “this
13 subtitle (and the amendments made by this subtitle and
14 section 401)” and inserting “the provisions of part 7 of
15 subtitle B of title I of the Employee Retirement Income
16 Security Act of 1974, the provisions of parts A and C of
17 title XXVII of the Public Health Service Act, and chapter
18 100 of the Internal Revenue Code of 1986”.

19 (e) MODIFICATION OF COVERAGE.—

20 (1) IN GENERAL.—The Secretary of Health and
21 Human Services may modify the coverage require-
22 ments for the amendments under this Act to allow
23 such requirements to incorporate and reflect new sci-
24 entific and technological advances regarding cancer
25 screening, practice pattern changes in such screen-

1 ing, or other updated medical practices regarding
2 such screening, such as the use of new tests or other
3 emerging technologies. Such modifications shall not
4 in any way diminish the coverage requirements listed
5 under this Act. Such modifications may be made on
6 the Secretary's own initiative or upon petition to the
7 Secretary by an individual or organization.

8 (2) CONSULTATION.—In modifying coverage re-
9 quirements under paragraph (1), the Secretary of
10 Health and Human Services shall consult with ap-
11 propriate organizations, experts, and agencies.

12 (3) PETITIONS.—The Secretary of Health and
13 Human Services may issue requirements for the pe-
14 titioning process under paragraph (1), including re-
15 quirements that the petition be in writing and in-
16 clude scientific or medical bases for the modification
17 sought. Upon receipt of such a petition, the Sec-
18 retary shall respond to the petitioner and decide
19 whether to propose a regulation proposing a change
20 within 90 days of such receipt. If a regulation is re-
21 quired, the Secretary shall propose such regulation
22 within 6 months of such determination. The Sec-
23 retary shall provide the petitioner the reasons for
24 the decision of the Secretary. The Secretary may

1 make changes requested by a petitioner in whole or
2 in part.

3 **SEC. 3. APPLICATION TO OTHER HEALTH CARE COVERAGE.**

4 Chapter 89 of title 5, United States Code, is amended
5 by adding at the end the following:

6 **“§ 8915. Standards relating to coverage of cancer**
7 **screening and patient access to informa-**
8 **tion**

9 “(a) The provisions of sections 2707 and 2708 of the
10 Public Health Service Act shall apply to the provision of
11 items and services under this chapter.

12 “(b) Nothing in this section or section 2707(c) of the
13 Public Health Service Act shall be construed as author-
14 izing a health insurance issuer or entity to impose cost
15 sharing with respect to the coverage or benefits required
16 to be provided under section 2707 of the Public Health
17 Service Act that is inconsistent with the cost sharing that
18 is otherwise permitted under this chapter.”.

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