

110TH CONGRESS  
1ST SESSION

# H. R. 3060

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title 5, United States Code, to require that group and individual health insurance coverage and group health plans and Federal employees health benefit plans provide coverage of colorectal cancer screening.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 17, 2007

Mr. BOREN (for himself and Mr. HALL of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight 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

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## A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and title 5, United States Code, to require that group and individual health insurance coverage and group health plans and Federal employees health benefit plans provide coverage of colorectal cancer screening.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Colorectal Cancer  
3 Screening and Detection Coverage Act of 2007”.

4 **SEC. 2. COVERAGE OF COLORECTAL CANCER SCREENING.**

5 (a) GROUP HEALTH PLANS.—

6 (1) PUBLIC HEALTH SERVICE ACT AMEND-  
7 MENTS.—

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

12 **“SEC. 2707. COVERAGE OF COLORECTAL CANCER SCREEN-**  
13 **ING.**

14 **“(a) REQUIREMENT.—**

15 **“(1) IN GENERAL.—**A group health plan, and a  
16 health insurance issuer offering group health insur-  
17 ance coverage, shall provide coverage under the plan  
18 or coverage, respectively, for colorectal cancer  
19 screening for any participant or beneficiary who is  
20 50 years of age or older, or is an individual who is  
21 at high risk for colorectal cancer (as defined in sec-  
22 tion 1861(pp)(2) of the Social Security Act (42  
23 U.S.C. 1395x(pp)(2)), under terms and conditions  
24 that are no less favorable than the terms and condi-  
25 tions applicable to other screening benefits otherwise  
26 provided under the plan or coverage, respectively.

1           “(2) COLORECTAL CANCER SCREENING DE-  
2           FINED.—For purposes of this section, the term  
3           ‘colorectal cancer screening’ means procedures  
4           that—

5                   “(A) are deemed appropriate by a physi-  
6                   cian (as defined in section 1861(r) of the Social  
7                   Security Act (42 U.S.C. 1395x(r))) treating the  
8                   participant or beneficiary, in consultation with  
9                   the participant or beneficiary;

10                   “(B) are—

11                           “(i) described in section 1861(pp)(1)  
12                           of the Social Security Act (42 U.S.C.  
13                           1395x(pp)(1)) or section 410.37 of title  
14                           42, Code of Federal Regulations;

15                           “(ii) specified by the Secretary for the  
16                           detection of colorectal cancer, based upon  
17                           the recommendations of appropriate orga-  
18                           nizations with special expertise in the field  
19                           of colorectal cancer, including the Amer-  
20                           ican Cancer Society and the American Col-  
21                           lege of Gastroenterology; or

22                           “(iii) specified by the Secretary, based  
23                           upon new scientific knowledge, techno-  
24                           logical advances, or other updated medical

1 practices with respect to detection of  
2 colorectal cancer; and

3 “(C) are performed at a frequency not  
4 greater than that—

5 “(i) described for such method in sec-  
6 tion 1834(d) of the Social Security Act (42  
7 U.S.C. 1395m(d)) or section 410.37 of  
8 title 42, Code of Federal Regulations; or

9 “(ii) specified by the Secretary for  
10 such method, if the Secretary finds, based  
11 upon new scientific knowledge, techno-  
12 logical advances, or other updated medical  
13 practices and consistent with the rec-  
14 ommendations of appropriate organizations  
15 with special expertise in the field of  
16 colorectal cancer, that a different fre-  
17 quency would not adversely affect the ef-  
18 fectiveness of such screening.

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

23 “(1) deny to an individual eligibility, or contin-  
24 ued eligibility, to enroll or to renew coverage under

1 the terms of the plan, solely for the purpose of  
2 avoiding the requirements of this section;

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

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

11 “(4) provide incentives (monetary or otherwise)  
12 to an attending provider to induce such provider to  
13 provide care to an individual participant or bene-  
14 ficiary in a manner inconsistent with this section.

15 “(c) RULES OF CONSTRUCTION.—

16 “(1) Nothing in this section shall be construed  
17 to require an individual who is a participant or bene-  
18 ficiary to undergo colorectal cancer screening.

19 “(2) Nothing in this section shall be construed  
20 as preventing a group health plan or issuer from im-  
21 posing deductibles, coinsurance, or other cost-shar-  
22 ing in relation to colorectal cancer screening under  
23 the plan (or under health insurance coverage offered  
24 in connection with a group health plan), except that  
25 such coinsurance or other cost-sharing shall not dis-

1 criminate on any basis related to the coverage re-  
2 quired under this section.

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

8 “(e) DISCLOSURE REQUIREMENT.—

9 “(1) IN GENERAL.—A group health plan, and  
10 health insurance issuer offering group health insur-  
11 ance coverage shall—

12 “(A) provide to participants and bene-  
13 ficiaries at the time of initial coverage under  
14 the plan (or the effective date of this section, in  
15 the case of individuals who are participants or  
16 beneficiaries as of such date), and at least an-  
17 nually thereafter, the information described in  
18 paragraph (2);

19 “(B) provide to participants and bene-  
20 ficiaries, within a reasonable period (as speci-  
21 fied by the appropriate Secretary) before or  
22 after the date of significant changes in the in-  
23 formation described in paragraph (2), informa-  
24 tion regarding such significant changes; and

1           “(C) upon request, make available to par-  
2           ticipants and beneficiaries, the applicable au-  
3           thority, and prospective participants and bene-  
4           ficiaries, the information described in para-  
5           graph (2).

6           “(2) INFORMATION DESCRIBED.—For purposes  
7           of paragraph (1), the information described in this  
8           paragraph, with respect to colorectal cancer screen-  
9           ing, is the following:

10           “(A) BENEFITS.—Benefits offered under  
11           the plan or coverage, including—

12           “(i) covered benefits, including benefit  
13           limits and coverage exclusions;

14           “(ii) cost sharing, such as deductibles,  
15           coinsurance, and copayment amounts, in-  
16           cluding any liability for balance billing, any  
17           maximum limitations on out of pocket ex-  
18           penses, and the maximum out of pocket  
19           costs for services that are provided by non-  
20           participating providers or that are fur-  
21           nished without meeting the applicable utili-  
22           zation review requirements;

23           “(iii) the extent to which benefits may  
24           be obtained from nonparticipating pro-  
25           viders; and

1 “(iv) the extent to which a partici-  
2 pant, beneficiary, or enrollee may select  
3 from among participating providers and  
4 the types of providers participating in the  
5 plan or issuer network.

6 “(B) ACCESS.—A description of the fol-  
7 lowing:

8 “(i) The number, mix, and distribu-  
9 tion of providers under the plan or cov-  
10 erage.

11 “(ii) Out-of-network coverage (if any)  
12 provided by the plan or coverage.

13 “(iii) Any point-of-service option (in-  
14 cluding any supplemental premium or cost-  
15 sharing for such option).

16 “(iv) The procedures for participants,  
17 beneficiaries, and enrollees to select, ac-  
18 cess, and change participating primary and  
19 specialty providers.

20 “(v) The rights and procedures for  
21 obtaining referrals (including standing re-  
22 ferrals) to participating and nonpartici-  
23 pating providers.

24 “(vi) The name, address, and tele-  
25 phone number of participating health care

1 providers and an indication of whether  
 2 each such provider is available to accept  
 3 new patients.

4 “(vii) How the plan or issuer address-  
 5 es the needs of participants, beneficiaries,  
 6 and enrollees and others who do not speak  
 7 English or who have other special commu-  
 8 nications needs in accessing providers  
 9 under the plan or coverage, including the  
 10 provision of information under this para-  
 11 graph.”.

12 (B) Section 2723(c) of such Act (42  
 13 U.S.C. 300gg-23(c)) is amended by striking  
 14 “section 2704” and inserting “sections 2704  
 15 and 2707”.

16 (2) ERISA AMENDMENTS.—

17 (A) Subpart B of part 7 of subtitle B of  
 18 title I of the Employee Retirement Income Se-  
 19 curity Act of 1974 is amended by adding at the  
 20 end the following new section:

21 **“SEC. 714. COVERAGE OF COLORECTAL CANCER SCREEN-**  
 22 **ING.**

23 “(a) REQUIREMENT.—

24 “(1) IN GENERAL.—A group health plan, and a  
 25 health insurance issuer offering group health insur-

1       ance coverage, shall provide coverage under the plan  
2       or coverage, respectively, for colorectal cancer  
3       screening for any participant or beneficiary who is  
4       50 years of age or older, or is an individual who is  
5       at high risk for colorectal cancer (as defined in sec-  
6       tion 1861(pp)(2) of the Social Security Act (42  
7       U.S.C. 1395x(pp)(2)), under terms and conditions  
8       that are no less favorable than the terms and condi-  
9       tions applicable to other screening benefits otherwise  
10      provided under the plan or coverage, respectively.

11           “(2) COLORECTAL CANCER SCREENING DE-  
12      FINED.—For purposes of this section, the term  
13      ‘colorectal cancer screening’ means procedures  
14      that—

15           “(A) are deemed appropriate by a physi-  
16      cian (as defined in section 1861(r) of the Social  
17      Security Act (42 U.S.C. 1395x(r))) treating the  
18      participant or beneficiary, in consultation with  
19      the participant or beneficiary;

20           “(B) are—

21           “(i) described in section 1861(pp)(1)  
22      of the Social Security Act (42 U.S.C.  
23      1395x(pp)(1)) or section 410.37 of title  
24      42, Code of Federal Regulations;

1           “(ii) specified by the Secretary for the  
2           detection of colorectal cancer, based upon  
3           the recommendations of appropriate orga-  
4           nizations with special expertise in the field  
5           of colorectal cancer, including the Amer-  
6           ican Cancer Society and the American Col-  
7           lege of Gastroenterology; or

8           “(iii) specified by the Secretary, based  
9           upon new scientific knowledge, techno-  
10          logical advances, or other updated medical  
11          practices with respect to detection of  
12          colorectal cancer; and

13          “(C) are performed at a frequency not  
14          greater than that—

15               “(i) described for such method in sec-  
16               tion 1834(d) of the Social Security Act (42  
17               U.S.C. 1395m(d)) or section 410.37 of  
18               title 42, Code of Federal Regulations; or

19               “(ii) specified by the Secretary for  
20               such method, if the Secretary finds, based  
21               upon new scientific knowledge, techno-  
22               logical advances, or other updated medical  
23               practices and consistent with the rec-  
24               ommendations of appropriate organizations  
25               with special expertise in the field of

1 colorectal cancer, that a different fre-  
2 quency would not adversely affect the ef-  
3 fectiveness of such screening.

4 “(b) PROTECTIONS.—A group health plan, and a  
5 health insurance issuer offering group health insurance  
6 coverage in connection with a group health plan, may  
7 not—

8 “(1) deny to an individual eligibility, or contin-  
9 ued eligibility, to enroll or to renew coverage under  
10 the terms of the plan, solely for the purpose of  
11 avoiding the requirements of this section;

12 “(2) provide monetary payments or rebates to  
13 individuals to encourage such individuals to accept  
14 less than the minimum protections available under  
15 this section;

16 “(3) penalize or otherwise reduce or limit the  
17 reimbursement of a provider because such provider  
18 provided care to an individual participant or bene-  
19 ficiary in accordance with this section; or

20 “(4) provide incentives (monetary or otherwise)  
21 to an attending provider to induce such provider to  
22 provide care to an individual participant or bene-  
23 ficiary in a manner inconsistent with this section.

24 “(c) RULES OF CONSTRUCTION.—

1           “(1) Nothing in this section shall be construed  
2           to require an individual who is a participant or bene-  
3           ficiary to undergo colorectal cancer screening.

4           “(2) Nothing in this section shall be construed  
5           as preventing a group health plan or issuer from im-  
6           posing deductibles, coinsurance, or other cost-shar-  
7           ing in relation to colorectal cancer screening under  
8           the plan (or under health insurance coverage offered  
9           in connection with a group health plan), except that  
10          such coinsurance or other cost-sharing shall not dis-  
11          criminate on any basis related to the coverage re-  
12          quired under this section.

13          “(d) NOTICE UNDER GROUP HEALTH PLAN.—The  
14          imposition of the requirements of this section shall be  
15          treated as a material modification in the terms of the plan  
16          described in section 102(a), for purposes of assuring no-  
17          tice of such requirements under the plan; except that the  
18          summary description required to be provided under the  
19          fourth sentence of section 104(b)(1) with respect to such  
20          modification shall be provided by not later than 60 days  
21          after the first day of the first plan year in which such  
22          requirements apply.

23          “(e) DISCLOSURE REQUIREMENT.—

1           “(1) IN GENERAL.—A group health plan, and  
2 health insurance issuer offering group health insur-  
3 ance coverage shall—

4           “(A) provide to participants and bene-  
5 ficiaries at the time of initial coverage under  
6 the plan (or the effective date of this section, in  
7 the case of individuals who are participants or  
8 beneficiaries as of such date), and at least an-  
9 nually thereafter, the information described in  
10 paragraph (2);

11           “(B) provide to participants and bene-  
12 ficiaries, within a reasonable period (as speci-  
13 fied by the appropriate Secretary) before or  
14 after the date of significant changes in the in-  
15 formation described in paragraph (2), informa-  
16 tion regarding such significant changes; and

17           “(C) upon request, make available to par-  
18 ticipants and beneficiaries, the applicable au-  
19 thority, and prospective participants and bene-  
20 ficiaries, the information described in para-  
21 graph (2).

22           “(2) INFORMATION DESCRIBED.—For purposes  
23 of paragraph (1), the information described in this  
24 paragraph, with respect to colorectal cancer screen-  
25 ing, is the following:

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

3           “(i) covered benefits, including benefit  
4 limits and coverage exclusions;

5           “(ii) cost sharing, such as deductibles,  
6 coinsurance, and copayment amounts, in-  
7 cluding any liability for balance billing, any  
8 maximum limitations on out of pocket ex-  
9 penses, and the maximum out of pocket  
10 costs for services that are provided by non-  
11 participating providers or that are fur-  
12 nished without meeting the applicable utili-  
13 zation review requirements;

14           “(iii) the extent to which benefits may  
15 be obtained from nonparticipating pro-  
16 viders; and

17           “(iv) the extent to which a partici-  
18 pant, beneficiary, or enrollee may select  
19 from among participating providers and  
20 the types of providers participating in the  
21 plan or issuer network.

22           “(B) ACCESS.—A description of the fol-  
23 lowing:

1           “(i) The number, mix, and distribu-  
2           tion of providers under the plan or cov-  
3           erage.

4           “(ii) Out-of-network coverage (if any)  
5           provided by the plan or coverage.

6           “(iii) Any point-of-service option (in-  
7           cluding any supplemental premium or cost-  
8           sharing for such option).

9           “(iv) The procedures for participants,  
10          beneficiaries, and enrollees to select, ac-  
11          cess, and change participating primary and  
12          specialty providers.

13          “(v) The rights and procedures for  
14          obtaining referrals (including standing re-  
15          ferrals) to participating and nonpartici-  
16          pating providers.

17          “(vi) The name, address, and tele-  
18          phone number of participating health care  
19          providers and an indication of whether  
20          each such provider is available to accept  
21          new patients.

22          “(vii) How the plan or issuer address-  
23          es the needs of participants, beneficiaries,  
24          and enrollees and others who do not speak  
25          English or who have other special commu-

1            communications needs in accessing providers  
 2            under the plan or coverage, including the  
 3            provision of information under this para-  
 4            graph.”.

5            (B) Section 731(c) of such Act (29 U.S.C.  
 6            1191(c)) is amended by striking “section 711”  
 7            and inserting “sections 711 and 714”.

8            (C) Section 732(a) of such Act (29 U.S.C.  
 9            1191a(a)) is amended by striking “section 711”  
 10           and inserting “sections 711 and 714”.

11           (D) The table of contents in section 1 of  
 12           such Act is amended by inserting after the item  
 13           relating to section 713 the following new item:

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

14           (3) INTERNAL REVENUE CODE AMEND-  
 15           MENTS.—

16           (A) Subchapter B of chapter 100 of the  
 17           Internal Revenue Code of 1986 is amended by  
 18           inserting after section 9812 the following new  
 19           section:

20           **“SEC. 9813. COVERAGE OF COLORECTAL CANCER SCREEN-**  
 21           **ING.**

22           “(a) REQUIREMENT.—

23           “(1) IN GENERAL.—A group health plan shall  
 24           provide coverage under the plan for colorectal cancer  
 25           screening for any participant or beneficiary who is

1 50 years of age or older, or is an individual who is  
2 at high risk for colorectal cancer (as defined in sec-  
3 tion 1861(pp)(2) of the Social Security Act (42  
4 U.S.C. 1395x(pp)(2)), under terms and conditions  
5 that are no less favorable than the terms and condi-  
6 tions applicable to other screening benefits otherwise  
7 provided under the plan.

8 “(2) COLORECTAL CANCER SCREENING DE-  
9 FINED.—For purposes of this section, the term  
10 ‘colorectal cancer screening’ means procedures  
11 that—

12 “(A) are deemed appropriate by a physi-  
13 cian (as defined in section 1861(r) of the Social  
14 Security Act (42 U.S.C. 1395x(r))) treating the  
15 participant or beneficiary, in consultation with  
16 the participant or beneficiary;

17 “(B) are—

18 “(i) described in section 1861(pp)(1)  
19 of the Social Security Act (42 U.S.C.  
20 1395x(pp)(1)) or section 410.37 of title  
21 42, Code of Federal Regulations;

22 “(ii) specified by the Secretary of  
23 Health and Human Services for the detec-  
24 tion of colorectal cancer, based upon the  
25 recommendations of appropriate organiza-

1 tions with special expertise in the field of  
2 colorectal cancer, including the American  
3 Cancer Society and the American College  
4 of Gastroenterology; or

5 “(iii) specified by the Secretary of  
6 Health and Human Services, based upon  
7 new scientific knowledge, technological ad-  
8 vances, or other updated medical practices  
9 with respect to detection of colorectal can-  
10 cer; and

11 “(C) are performed at a frequency not  
12 greater than that—

13 “(i) described for such method in sec-  
14 tion 1834(d) of the Social Security Act (42  
15 U.S.C. 1395m(d)) or section 410.37 of  
16 title 42, Code of Federal Regulations; or

17 “(ii) specified by the Secretary of  
18 Health and Human Services for such  
19 method, if such Secretary finds, based  
20 upon new scientific knowledge, techno-  
21 logical advances, or other updated medical  
22 practices and consistent with the rec-  
23 ommendations of appropriate organizations  
24 with special expertise in the field of  
25 colorectal cancer, that a different fre-

1                   quency would not adversely affect the ef-  
2                   fectiveness of such screening.

3           “(b) PROTECTIONS.—A group health plan may not—

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

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

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

16                  “(4) provide incentives (monetary or otherwise)  
17                  to an attending provider to induce such provider to  
18                  provide care to an individual participant or bene-  
19                  ficiary in a manner inconsistent with this section.

20           “(c) RULES OF CONSTRUCTION.—

21                  “(1) Nothing in this section shall be construed  
22                  to require an individual who is a participant or bene-  
23                  ficiary to undergo colorectal cancer screening.

24                  “(2) Nothing in this section shall be construed  
25                  as preventing a group health plan from imposing

1 deductibles, coinsurance, or other cost-sharing in re-  
2 lation to colorectal cancer screening under the plan,  
3 except that such coinsurance or other cost-sharing  
4 shall not discriminate on any basis related to the  
5 coverage required under this section.

6 “(d) DISCLOSURE REQUIREMENT.—

7 “(1) IN GENERAL.—A group health plan  
8 shall—

9 “(A) provide to participants and bene-  
10 ficiaries at the time of initial coverage under  
11 the plan (or the effective date of this section, in  
12 the case of individuals who are participants or  
13 beneficiaries as of such date), and at least an-  
14 nually thereafter, the information described in  
15 paragraph (2);

16 “(B) provide to participants and bene-  
17 ficiaries, within a reasonable period (as speci-  
18 fied by the appropriate Secretary) before or  
19 after the date of significant changes in the in-  
20 formation described in paragraph (2), informa-  
21 tion regarding such significant changes; and

22 “(C) upon request, make available to par-  
23 ticipants and beneficiaries, the applicable au-  
24 thority, and prospective participants and bene-

1           ficiaries, the information described in para-  
2           graph (2).

3           “(2) INFORMATION DESCRIBED.—For purposes  
4           of paragraph (1), the information described in this  
5           paragraph, with respect to colorectal cancer screen-  
6           ing, is the following:

7                   “(A) BENEFITS.—Benefits offered under  
8           the plan, including—

9                           “(i) covered benefits, including benefit  
10                           limits and coverage exclusions;

11                           “(ii) cost sharing, such as deductibles,  
12                           coinsurance, and copayment amounts, in-  
13                           cluding any liability for balance billing, any  
14                           maximum limitations on out of pocket ex-  
15                           penses, and the maximum out of pocket  
16                           costs for services that are provided by non-  
17                           participating providers or that are fur-  
18                           nished without meeting the applicable utili-  
19                           zation review requirements;

20                           “(iii) the extent to which benefits may  
21                           be obtained from nonparticipating pro-  
22                           viders; and

23                           “(iv) the extent to which a partici-  
24                           pant, beneficiary, or enrollee may select  
25                           from among participating providers and

1 the types of providers participating in the  
2 plan or issuer network.

3 “(B) ACCESS.—A description of the fol-  
4 lowing:

5 “(i) The number, mix, and distribu-  
6 tion of providers under the plan.

7 “(ii) Out-of-network coverage (if any)  
8 provided by the plan.

9 “(iii) Any point-of-service option (in-  
10 cluding any supplemental premium or cost-  
11 sharing for such option).

12 “(iv) The procedures for participants,  
13 beneficiaries, and enrollees to select, ac-  
14 cess, and change participating primary and  
15 specialty providers.

16 “(v) The rights and procedures for  
17 obtaining referrals (including standing re-  
18 ferrals) to participating and nonpartici-  
19 pating providers.

20 “(vi) The name, address, and tele-  
21 phone number of participating health care  
22 providers and an indication of whether  
23 each such provider is available to accept  
24 new patients.

1                   “(vii) How the plan or issuer address-  
 2                   es the needs of participants, beneficiaries,  
 3                   and enrollees and others who do not speak  
 4                   English or who have other special commu-  
 5                   nications needs in accessing providers  
 6                   under the plan, including the provision of  
 7                   information under this paragraph.”.

8                   (B) The table of sections of such sub-  
 9                   chapter of such Code is amended by inserting  
 10                  after the item relating to section 9812 the fol-  
 11                  lowing new item:

“Sec. 9813. Coverage of colorectal cancer screening.”.

12                  (C) Section 4980D(d)(1) of such Code is  
 13                  amended by striking “section 9811” and insert-  
 14                  ing “sections 9811 and 9813”.

15                  (b) INDIVIDUAL HEALTH INSURANCE.—

16                  (1) IN GENERAL.—Part B of title XXVII of the  
 17                  Public Health Service Act is amended by inserting  
 18                  after section 2752 the following new section:

19                  **“SEC. 2753. COVERAGE OF COLORECTAL CANCER SCREEN-**  
 20                  **ING.**

21                  “(a) IN GENERAL.—The provisions of section 2707  
 22                  (other than subsection (d)) shall apply to health insurance  
 23                  coverage offered by a health insurance issuer in the indi-  
 24                  vidual market in the same manner as it applies to health  
 25                  insurance coverage offered by a health insurance issuer

1 in connection with a group health plan in the small or  
2 large group market.

3 “(b) NOTICE.—A health insurance issuer under this  
4 part shall comply with the notice requirement under sec-  
5 tion 714(d) of the Employee Retirement Income Security  
6 Act of 1974 with respect to the requirements referred to  
7 in subsection (a) as if such section applied to such issuer  
8 and such issuer were a group health plan.”.

9 (2) CONFORMING AMENDMENT.—Section  
10 2762(b)(2) of such Act (42 U.S.C. 300gg–63(b)(2))  
11 is amended by striking “section 2751” and inserting  
12 “sections 2751 and 2753”.

13 (c) APPLICATION UNDER FEDERAL EMPLOYEES  
14 HEALTH BENEFITS PROGRAM (FEHBP).—Section 8902  
15 of title 5, United States Code, is amended by adding at  
16 the end the following new subsection:

17 “(p) A contract may not be made or a plan approved  
18 which does not comply with the requirements of section  
19 2707 of the Public Health Service Act.”.

20 (d) EFFECTIVE DATES.—

21 (1) GROUP HEALTH PLANS AND HEALTH BEN-  
22 EFIT PLANS.—The amendments made by subsections  
23 (a) and (c) shall apply with respect to group health  
24 plans (and health insurance coverage offered in con-  
25 nection with group health plans) and health benefit

1 plans, respectively, for plan years beginning on or  
2 after January 1, 2008.

3 (2) INDIVIDUAL HEALTH INSURANCE.—The  
4 amendments made by subsection (b) shall apply with  
5 respect to health insurance coverage offered, sold,  
6 issued, or renewed in the individual market on or  
7 after January 1, 2008.

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

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

19 (2) coordination of policies relating to enforcing  
20 the same requirements through such Secretaries in  
21 order to have a coordinated enforcement strategy  
22 that avoids duplication of enforcement efforts and  
23 assigns priorities in enforcement.

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