

104<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 3630

To require coverage of screening mammography and pap smears under health plans.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 12, 1996

Mr. FOX of Pennsylvania (for himself, Mr. GENE GREEN of Texas, Mr. LIPINSKI, Mrs. ROUKEMA, Mr. DAVIS, and Mr. FORBES) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Economic and Educational Opportunities, 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 require coverage of screening mammography and pap smears under health plans.

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 “Women’s Preventive  
5 Health Care Act of 1996”.

1 **SEC. 2. REQUIRING COVERAGE OF SCREENING MAMMOG-**  
2 **RAPHY AND PAP SMEARS UNDER HEALTH**  
3 **PLANS.**

4 (a) IN GENERAL.—Every policy or contract that pro-  
5 vides health insurance coverage (as defined in subsection  
6 (h)(1)) and every group health plan (as defined in sub-  
7 section (h)(2)) shall include (consistent with this sec-  
8 tion)—

- 9 (1) coverage for screening pap smears, and  
10 (2) coverage for low-dose screening mammog-  
11 raphy.

12 (b) DEFINITIONS RELATING TO COVERAGE.—In this  
13 section:

14 (1) LOW-DOSE SCREENING MAMMOGRAPHY.—  
15 The term “low-dose screening mammography”  
16 means a radiologic procedure for the early detection  
17 of breast cancer provided to an asymptomatic  
18 women using equipment dedicated specifically for  
19 mammography and at a facility which meets mam-  
20 mography accreditation standards established by the  
21 Secretary for coverage of screening mammography  
22 under the medicare program under title XVIII of the  
23 Social Security Act. Such term also includes a physi-  
24 cian’s interpretation of the results of the procedure.

25 (2) SCREENING PAP SMEAR.—The term  
26 “screening pap smear” means a diagnostic labora-

1 tory test consisting of a routine exfoliative cytology  
2 test (Papanicolaou test) provided to a woman for the  
3 purpose of early detection of cervical cancer and in-  
4 cludes the examination, the laboratory test itself,  
5 and a physician's interpretation of the results of the  
6 test. If the Secretary establishes qualify standards  
7 for facilities furnishing screening pap smears, such  
8 term shall only include a test if the test is performed  
9 in a facility that has been determined to meet such  
10 standards.

11 (c) RESTRICTIONS ON COST-SHARING.—The cov-  
12 erage under this section shall not provide for the applica-  
13 tion of deductibles, coinsurance, or other limitations for  
14 low-dose screening mammography or screening pap  
15 smears that are greater than the deductibles, coinsurance,  
16 and limitations that are applied to similar services under  
17 the health insurance coverage or group health plan.

18 (d) FREQUENCY OF COVERAGE OF SCREENING MAM-  
19 MOGRAPHY.—

20 (1) IN GENERAL.—Coverage of low-dose screen-  
21 ing mammography is consistent with this section  
22 only if it is provided consistent with the following  
23 periodicity schedule:

1 (A) Coverage is made available for one  
2 baseline low-dose screening mammography for  
3 any woman between 35 and 40 years of age.

4 (B) Coverage is made available for such  
5 mammography on an annual basis to any  
6 woman who is 50 years or age or older or who  
7 is determined by a physician to be at-risk of  
8 breast cancer (as defined in paragraph (2)).

9 (C) Coverage is made available for such  
10 mammography for a woman at least once every  
11 other year.

12 (2) AT-RISK OF BREAST CANCER.—For pur-  
13 poses of paragraph (1)(B), a woman is considered to  
14 be “at-risk of breast cancer” if any of the following  
15 is true:

16 (A) The woman has a personal history of  
17 breast cancer.

18 (B) The woman has a personal history of  
19 biopsy-proven benign breast disease.

20 (C) The woman’s mother, sister, or daugh-  
21 ter has or has had breast cancer.

22 (D) The woman has not given birth prior  
23 to the age of 30.

24 (e) FREQUENCY OF COVERAGE OF SCREENING PAP  
25 SMEARS.—Coverage of screening pap smears is consistent

1 with this section only if it is provided not more often than  
2 once every year (or more frequently if recommended by  
3 a physician).

4 (f) ENFORCEMENT.—

5 (1) REGULATED INSURERS.—It is the respon-  
6 sibility of State regulators what regulate insurers  
7 that offer health insurance coverage in a State to  
8 apply the requirements of this section to such insur-  
9 ers and coverage. If the Secretary determines that  
10 such regulators do not have the intent or means of  
11 enforcing such requirements with respect to such in-  
12 surers in a State, the Secretary may provide such  
13 remedies (which may include civil money penalties)  
14 as may be necessary to assure compliance with the  
15 requirements of this section in such State.

16 (2) GROUP HEALTH PLANS.—The requirements  
17 of this section are deemed, in relation to group  
18 health plans offered as employee welfare benefit  
19 plans under title I of Employee Retirement Income  
20 Security Act of 1974, to be provisions of such title,  
21 for purposes of applying the enforcement related  
22 provisions of such title.

23 (3) OTHER PLANS.—In the case of health cov-  
24 erage not described in paragraph (1) or (2), the Sec-  
25 retary shall develop such non-criminal enforcement

1 mechanisms as may be necessary and appropriate to  
2 carry out this section in relation to entities offering  
3 such coverage.

4 (g) RELATION TO STATE LAW.—The provisions of  
5 this section do not preempt State law to the extent such  
6 State law provides greater protection to women in relation  
7 to the benefits provided under this section.

8 (h) DEFINITIONS.—In this section:

9 (1) HEALTH INSURANCE COVERAGE.—

10 (A) IN GENERAL.—Except as provided in  
11 subparagraph (B), the term “health insurance  
12 coverage” means benefits consisting of medical  
13 care (provided directly, through insurance or re-  
14 imbursement, or otherwise) under any hospital  
15 or medical service policy or certificate, hospital  
16 or medical service plan contract, or health  
17 maintenance organization group contract of-  
18 fered by an insurer or a health maintenance or-  
19 ganization.

20 (B) EXCEPTION.—Such term does not in-  
21 clude coverage under any separate policy, cer-  
22 tificate, or contract only for one or more of any  
23 of the following:

24 (i) Coverage for accident, credit-only,  
25 vision, disability income, long-term care,

1 nursing home care, community-based care  
2 dental, on-site medical clinics, or employee  
3 assistance programs, or any combination  
4 thereof.

5 (ii) Medicare supplemental health in-  
6 surance (within the meaning of section  
7 1882(g)(1) of the Social Security Act (42  
8 U.S.C. 1395ss(g)(1))) and similar supple-  
9 mental coverage provided under a group  
10 health plan.

11 (iii) Coverage issued as a supplement  
12 to liability insurance.

13 (iv) Liability insurance, including gen-  
14 eral liability insurance and automobile li-  
15 ability insurance.

16 (v) Workers' compensation or similar  
17 insurance.

18 (vi) Automobile medical-payment in-  
19 surance.

20 (vii) Coverage for a specified disease  
21 or illness.

22 (viii) Hospital or fixed indemnity in-  
23 surance.

24 (ix) Short-term limited duration in-  
25 surance.

1                   (x) Such other coverage, comparable  
2                   to that described in previous clauses, as  
3                   may be specified in regulations prescribed  
4                   by the Secretary.

5                   (2) GROUP HEALTH PLAN.—

6                   (A) IN GENERAL.—Subject to subpara-  
7                   graph (B), the term “group health plan” means  
8                   an employee welfare benefit plan (as defined in  
9                   section 3 of the Employee Retirement Income  
10                  Security Act of 1974) to the extent that the  
11                  plan provides medical care (as defined in para-  
12                  graph (5)) to employees or their dependents (as  
13                  defined under the terms of the plan) directly or  
14                  through insurance, reimbursement, or other-  
15                  wise, and includes a group health plan (within  
16                  the meaning of section 5000(b)(1) of the Inter-  
17                  nal Revenue Code of 1986).

18                  (B) EXCLUSION OF PLANS WITH LIMITED  
19                  COVERAGE.—An employee welfare benefit plan  
20                  shall be treated as a group health plan under  
21                  this section only with respect to medical care  
22                  which is provided under the plan and which  
23                  does not consist of coverage excluded from the  
24                  definition of health insurance coverage under  
25                  paragraph (1)(B).

1           (3) HEALTH MAINTENANCE ORGANIZATION.—

2           The term “health maintenance organization”  
3           means—

4                   (A) a Federally qualified health mainte-  
5                   nance organization (as defined in section  
6                   1301(a) of the Public Health Service Act (42  
7                   U.S.C. 300e(a))),

8                   (B) an organization recognized under State  
9                   law as a health maintenance organization, or

10                   (C) a similar organization regulated under  
11                   State law for solvency in the same manner and  
12                   to the same extent as such a health mainte-  
13                   nance organization,

14           if it is subject to State law which regulates insur-  
15           ance (within the meaning of section 514(b)(2) of the  
16           Employee Retirement Income Security Act of 1974).

17           (4) INSURER.—The term “insurer” means an  
18           insurance company, insurance service, or insurance  
19           organization which is licensed to engage in the busi-  
20           ness of insurance in a State and which is subject to  
21           State law which regulates insurance (within the  
22           meaning of section 514(b)(2)(A) of the Employee  
23           Retirement Income Security Act of 1974).

24           (5) MEDICAL CARE.—The term “medical care”  
25           means—

1 (A) amounts paid for, or items or services  
2 in the form of, the diagnosis, cure, mitigation,  
3 treatment, or prevention of disease, or amounts  
4 paid for, or items or services provided for, the  
5 purpose of affecting any structure or function  
6 of the body,

7 (B) amounts paid for, or services in the  
8 form of, transportation primarily for and essen-  
9 tial to medical care referred to in subparagraph  
10 (A), and

11 (C) amounts paid for insurance covering  
12 medical care referred to in subparagraphs (A)  
13 and (B).

14 (6) SECRETARY.—The term “Secretary” means  
15 the Secretary of Health and Human Services.

16 (7) STATE.—The term “State” includes the  
17 District of Columbia, Puerto Rico, the Virgin Is-  
18 lands, the Northern Mariana Islands, Guam, and  
19 American Samoa.

20 (i) EFFECTIVE DATE.—This section shall apply to  
21 health insurance coverage that is issued, renewed, or  
22 amended on or after January 1, 1997, and to group health  
23 plans for plan years beginning on or after such date.

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