

107TH CONGRESS
1ST SESSION

S. 868

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 SENATE OF THE UNITED STATES

MAY 10, 2001

Mrs. FEINSTEIN introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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.—

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

3 (A) IN GENERAL.—Subpart 2 of part A of
4 title XXVII of the Public Health Service Act
5 (42 U.S.C. 300gg–4 et seq.) is amended by
6 adding at the end the following:

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

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

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

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 provide coverage for
8 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 a first degree family
19 member), 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, shall
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.—A group health plan under this part
21 shall comply with the notice requirement under section
22 714(d) of the Employee Retirement Income Security Act
23 of 1974 with respect to the requirements of this section
24 as if such section applied to such plan.

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

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

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

9 “(3) has the presence of an appropriate recog-
10 nized gene marker that is identified as putting the
11 individual at a higher risk of developing that type of
12 cancer; or

13 “(4) has other predisposing factors that signifi-
14 cantly increases the risk of the individual con-
15 tracting that type of cancer.

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

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

20 “(a) DISCLOSURE REQUIREMENT.—A group health
21 plan, and health insurance issuer offering group health in-
22 surance coverage shall—

23 “(1) provide to participants and beneficiaries at
24 the time of initial coverage under the plan (or the
25 effective date of this section, in the case of individ-

1 uals who are participants or beneficiaries as of such
2 date), and at least annually thereafter, the informa-
3 tion described in subsection (b) in printed form;

4 “(2) provide to participants and beneficiaries,
5 within a reasonable period (as specified by the ap-
6 propriate Secretary) before or after the date of sig-
7 nificant changes in the information described in sub-
8 section (b), information in printed form regarding
9 such significant changes; and

10 “(3) upon request, make available to partici-
11 pants and beneficiaries, the applicable authority, and
12 prospective participants and beneficiaries, the infor-
13 mation described in subsection (b) in printed form.

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

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

20 “(A) covered benefits, including benefit
21 limits and coverage exclusions;

22 “(B) cost sharing, such as deductibles, co-
23 insurance, and copayment amounts, including
24 any liability for balance billing, any maximum
25 limitations on out of pocket expenses, and the

1 maximum out of pocket costs for services that
2 are provided by nonparticipating providers or
3 that are furnished without meeting the applica-
4 ble utilization review requirements;

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

7 “(D) the extent to which a participant,
8 beneficiary, or enrollee may select from among
9 participating providers and the types of pro-
10 viders participating in the plan or issuer net-
11 work.

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

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

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

17 “(C) Any point-of-service option (including
18 any supplemental premium or cost-sharing for
19 such option).

20 “(D) The procedures for participants,
21 beneficiaries, and enrollees to select, access, and
22 change participating primary and specialty pro-
23 viders.

1 “(E) The rights and procedures for obtain-
2 ing referrals (including standing referrals) to
3 participating and nonparticipating providers.

4 “(F) The name, address, and telephone
5 number of participating health care providers
6 and an indication of whether each such provider
7 is available to accept new patients.

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

15 (B) TECHNICAL AMENDMENT.—Section
16 2723(c) of the Public Health Service Act (42
17 U.S.C. 300gg–23(c)) is amended by striking
18 “section 2704” and inserting “sections 2704
19 and 2707”.

20 (2) ERISA AMENDMENTS.—

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

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

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

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

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

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

24 “(B) is at least 20, but less than 40, years
25 of age and who is not at high risk of developing

1 breast cancer, a clinical breast examination
2 each 3 years.

3 “(3) PAPANICOLAOU TESTS AND PELVIC EXAMINATIONS.—

4 In the case of a female participant or beneficiary
5 who is 18 years of age or older, or who is under 18
6 years of age and is or has been sexually active—

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

15 “(B) an annual pelvic examination.

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

1 or health insurance issuer shall provided coverage
2 for the method and frequency of colorectal cancer
3 screening determined to be appropriate by a health
4 care provider treating such participant or bene-
5 ficiary, in consultation with the participant or bene-
6 ficiary.

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

23 “(6) OTHER TESTS AND PROCEDURES.—Such
24 other tests or procedures for the detection of cancer,
25 and modifications to the tests and procedures, with

1 such frequency, as the Secretary determines to be
2 appropriate, in consultation with appropriate organi-
3 zations and agencies, for the diagnosis or detection
4 of cancer.

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

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

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

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

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

25 “(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 a procedure, examination, or test
4 described in subsection (a).

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

13 “(d) NOTICE UNDER GROUP HEALTH PLAN.—The
14 imposition of the requirement of this section shall be treat-
15 ed as a material modification in the terms of the plan de-
16 scribed in section 102(a), for purposes of assuring notice
17 of such requirements under the plan; except that the sum-
18 mary description required to be provided under the last
19 sentence of section 104(b)(1) with respect to such modi-
20 fication shall be provided by not later than 60 days after
21 the first day of the first plan year in which such require-
22 ment apply.

23 “(e) HIGH RISK DEFINED.—For purposes of this
24 section, an individual is considered to be at ‘high risk’ of
25 developing a particular type of cancer if, under guidelines

1 developed or recognized by the Secretary based upon sci-
2 entific evidence, the individual—

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

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

6 “(3) has the presence of an appropriate recog-
7 nized gene marker that is identified as putting the
8 individual at a higher risk of developing that type of
9 cancer; or

10 “(4) has other predisposing factors that signifi-
11 cantly increases the risk of the individual con-
12 tracting that type of cancer.

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

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

17 “(a) DISCLOSURE REQUIREMENT.—A group health
18 plan, and health insurance issuer offering group health in-
19 surance coverage shall—

20 “(1) provide to participants and beneficiaries at
21 the time of initial coverage under the plan (or the
22 effective date of this section, in the case of individ-
23 uals who are participants or beneficiaries as of such
24 date), and at least annually thereafter, the informa-
25 tion described in subsection (b) in printed form;

1 “(2) provide to participants and beneficiaries,
2 within a reasonable period (as specified by the ap-
3 propriate Secretary) before or after the date of sig-
4 nificant changes in the information described in sub-
5 section (b), information in printed form regarding
6 such significant changes; and

7 “(3) upon request, make available to partici-
8 pants and beneficiaries, the applicable authority, and
9 prospective participants and beneficiaries, the infor-
10 mation described in subsection (b) in printed form.

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

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

17 “(A) covered benefits, including benefit
18 limits and coverage exclusions;

19 “(B) cost sharing, such as deductibles, co-
20 insurance, and copayment amounts, including
21 any liability for balance billing, any maximum
22 limitations on out of pocket expenses, and the
23 maximum out of pocket costs for services that
24 are provided by nonparticipating providers or

1 that are furnished without meeting the applica-
2 ble utilization review requirements;

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

5 “(D) the extent to which a participant,
6 beneficiary, or enrollee may select from among
7 participating providers and the types of pro-
8 viders participating in the plan or issuer net-
9 work.

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

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

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

15 “(C) Any point-of-service option (including
16 any supplemental premium or cost-sharing for
17 such option).

18 “(D) The procedures for participants,
19 beneficiaries, and enrollees to select, access, and
20 change participating primary and specialty pro-
21 viders.

22 “(E) The rights and procedures for obtain-
23 ing referrals (including standing referrals) to
24 participating and nonparticipating providers.

1 “(F) The name, address, and telephone
2 number of participating health care providers
3 and an indication of whether each such provider
4 is available to accept new patients.

5 “(G) How the plan or issuer addresses the
6 needs of participants, beneficiaries, and enroll-
7 ees and others who do not speak English or
8 who have other special communications needs in
9 accessing providers under the plan or coverage,
10 including the provision of information under
11 this subsection.”.

12 (B) TECHNICAL AMENDMENTS.—

13 (i) Section 731(c) of the Employee
14 Retirement Income Security Act of 1974
15 (29 U.S.C. 1191(c)) is amended by strik-
16 ing “section 711” and inserting “sections
17 711 and 714”.

18 (ii) Section 732(a) of the Employee
19 Retirement Income Security Act of 1974
20 (29 U.S.C. 1191a(a)) is amended by strik-
21 ing “section 711” and inserting “sections
22 711 and 714”.

23 (iii) The table of contents in section 1
24 of the Employee Retirement Income Secu-
25 rity Act of 1974 is amended by inserting

1 after the item relating to section 713 the
2 following new items:

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

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

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

6 (A) in the table of sections, by inserting
7 after the item relating to section 9812 the fol-
8 lowing new items:

“Sec. 9813. Coverage of cancer screening.

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

9 (B) by inserting after section 9812 the fol-
10 lowing:

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

12 “(a) REQUIREMENT.—A group health plan shall pro-
13 vide coverage and payment under the plan for the fol-
14 lowing items and services under terms and conditions that
15 are no less favorable than the terms and conditions appli-
16 cable to other screening benefits otherwise provided under
17 the plan:

18 “(1) MAMMOGRAMS.—In the case of a female
19 participant or beneficiary who is 40 years of age or
20 older, or is under 40 years of age but is at high risk
21 (as defined in subsection (d)) of developing breast
22 cancer, an annual mammography (as defined in sec-
23 tion 1861(jj) of the Social Security Act) conducted

1 by a facility that has a certificate (or provisional cer-
2 tificate) issued under section 354 of the Public
3 Health Service Act.

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

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

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

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

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

1 “(B) an annual pelvic examination.

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

18 “(5) PROSTATE CANCER SCREENING.—In the
19 case of a male participant or beneficiary who is 50
20 years of age or older, or who is younger than 50
21 years of age and is at high risk for prostate cancer
22 (including African American men or a male who has
23 a history of prostate cancer in a first degree family
24 member), the procedures described in section
25 1861(oo)(2) of Social Security Act (42 U.S.C.

1 1395x(oo)(2)) shall be furnished to the individual
2 for the early detection of prostate cancer. The group
3 health plan or health insurance issuer shall provide
4 coverage for the method and frequency of prostate
5 cancer screening determined to be appropriate by a
6 health care provider treating such participant or
7 beneficiary, in consultation with the participant or
8 beneficiary.

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

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

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

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

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

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

9 “(c) RULES OF CONSTRUCTION.—

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

14 “(2) Nothing in this section shall be construed
15 as preventing a group health plan from imposing
16 deductibles, coinsurance, or other cost-sharing in re-
17 lation to benefits described in subsection (a) con-
18 sistent with such subsection, except that such coin-
19 surance or other cost-sharing shall not discriminate
20 on any basis related to the coverage required under
21 this section.

22 “(d) HIGH RISK DEFINED.—For purposes of this
23 section, an individual is considered to be at ‘high risk’ of
24 developing a particular type of cancer if, under guidelines

1 developed or recognized by the Secretary based upon sci-
2 entific evidence, the individual—

3 “(1) has one or more first degree family mem-
4 bers who have developed that type of cancer;

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

6 “(3) has the presence of an appropriate recog-
7 nized gene marker that is identified as putting the
8 individual at a higher risk of developing that type of
9 cancer; or

10 “(4) has other predisposing factors that signifi-
11 cantly increases the risk of the individual con-
12 tracting that type of cancer.

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

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

17 “(a) DISCLOSURE REQUIREMENT.—A group health
18 plan, and health insurance issuer offering group health in-
19 surance coverage shall—

20 “(1) provide to participants and beneficiaries at
21 the time of initial coverage under the plan (or the
22 effective date of this section, in the case of individ-
23 uals who are participants or beneficiaries as of such
24 date), and at least annually thereafter, the informa-
25 tion described in subsection (b) in printed form;

1 “(2) provide to participants and beneficiaries,
2 within a reasonable period (as specified by the ap-
3 propriate Secretary) before or after the date of sig-
4 nificant changes in the information described in sub-
5 section (b), information in printed form regarding
6 such significant changes; and

7 “(3) upon request, make available to partici-
8 pants and beneficiaries, the applicable authority, and
9 prospective participants and beneficiaries, the infor-
10 mation described in subsection (b) in printed form.

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

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

17 “(A) covered benefits, including benefit
18 limits and coverage exclusions;

19 “(B) cost sharing, such as deductibles, co-
20 insurance, and copayment amounts, including
21 any liability for balance billing, any maximum
22 limitations on out of pocket expenses, and the
23 maximum out of pocket costs for services that
24 are provided by nonparticipating providers or

1 that are furnished without meeting the applica-
2 ble utilization review requirements;

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

5 “(D) the extent to which a participant,
6 beneficiary, or enrollee may select from among
7 participating providers and the types of pro-
8 viders participating in the plan or issuer net-
9 work.

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

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

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

15 “(C) Any point-of-service option (including
16 any supplemental premium or cost-sharing for
17 such option).

18 “(D) The procedures for participants,
19 beneficiaries, and enrollees to select, access, and
20 change participating primary and specialty pro-
21 viders.

22 “(E) The rights and procedures for obtain-
23 ing referrals (including standing referrals) to
24 participating and nonparticipating providers.

1 nection with a group health plan in the small or large
2 group market to a participant or beneficiary in such plan.

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

10 The provisions of section 2708 shall apply health in-
11 surance coverage offered by a health insurance issuer in
12 the individual market with respect to an enrollee under
13 such coverage in the same manner as they apply to health
14 insurance coverage offered by a health insurance issuer
15 in connection with a group health plan in the small or
16 large group market to a participant or beneficiary in such
17 plan.”.

18 (2) TECHNICAL AMENDMENT.—Section
19 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))
20 is amended by striking “section 2751” and inserting
21 “sections 2751 and 2753”.

22 (c) EFFECTIVE DATES.—

23 (1) GROUP HEALTH PLANS.—Subject to para-
24 graph (3), the amendments made by subsection (a)

1 shall apply with respect to group health plans for
2 plan years beginning on or after January 1, 2002.

3 (2) INDIVIDUAL PLANS.—The amendment made
4 by subsection (b) shall apply with respect to health
5 insurance coverage offered, sold, issued, renewed, in
6 effect, or operated in the individual market on or
7 after such date.

8 (3) COLLECTIVE BARGAINING AGREEMENT.—In
9 the case of a group health plan maintained pursuant
10 to 1 or more collective bargaining agreements be-
11 tween employee representatives and 1 or more em-
12 ployers ratified before the date of enactment of this
13 Act, the amendments made to subsection (a) shall
14 not apply to plan years beginning before the later
15 of—

16 (A) the date on which the last collective
17 bargaining agreements relating to the plan ter-
18 minates (determined without regard to any ex-
19 tension thereof agreed to after the date of en-
20 actment of this Act), or

21 (B) January 1, 2002.

22 For purposes of subparagraph (A), any plan amend-
23 ment made pursuant to a collective bargaining
24 agreement relating to the plan which amends the
25 plan solely to conform to any requirement added by

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

3 (d) COORDINATED REGULATIONS.—Section 104(1)
4 of Health Insurance Portability and Accountability Act of
5 1996 (Public Law 104–191) is amended by striking “this
6 subtitle (and the amendments made by this subtitle and
7 section 401)” and inserting “the provisions of part 7 of
8 subtitle B of title I of the Employee Retirement Income
9 Security Act of 1974, the provisions of parts A and C of
10 title XXVII of the Public Health Service Act, and chapter
11 100 of the Internal Revenue Code of 1986”.

12 (e) MODIFICATION OF COVERAGE.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services may modify the coverage require-
15 ments for the amendments under this Act to allow
16 such requirements to incorporate and reflect new sci-
17 entific and technological advances regarding cancer
18 screening, practice pattern changes in such screen-
19 ing, or other updated medical practices regarding
20 such screening, such as the use of new tests or other
21 emerging technologies. Such modifications shall not
22 in any way diminish the coverage requirements listed
23 under this Act. Such modifications may be made on
24 the Secretary’s own initiative or upon petition to the
25 Secretary by an individual or organization.

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

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

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

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

1 **“§ 8915. Standards relating to coverage of cancer**
2 **screening and patient access to informa-**
3 **tion.**

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

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

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