

108TH CONGRESS
1ST SESSION

H. R. 3362

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 screening for breast, prostate, and colorectal cancer.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 21, 2003

Mrs. MALONEY 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 screening for breast, prostate, and colorectal cancer.

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 “Cancer Screening Cov-
3 erage Act of 2003”.

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

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:

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

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

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

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

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

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

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

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

25 “(B) an annual pelvic examination.

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

17 “(5) PROSTATE CANCER SCREENING.—In the
18 case of a male participant or beneficiary who is 50
19 years of age or older, or who is younger than 50
20 years of age and is at high risk for prostate cancer
21 (including African American men or a male who has
22 a history of prostate cancer in 1 or more first degree
23 family members), the procedures described in section
24 1861(oo)(2) of Social Security Act (42 U.S.C.
25 1395x(oo)(2)) shall be furnished to the individual

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

8 “(b) PROHIBITIONS.—A group health plan, and a
9 health insurance issuer offering group health insurance
10 coverage in connection with a group health plan, shall
11 not—

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

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

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

24 “(4) provide incentives (monetary or otherwise)
25 to a provider to induce such provider to provide care

1 to an individual participant or beneficiary in a man-
2 ner inconsistent with this section.

3 “(c) RULES OF CONSTRUCTION.—

4 “(1) Nothing in this section shall be construed
5 to require an individual who is a participant or bene-
6 ficiary to undergo a procedure, examination, or test
7 described in subsection (a).

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

16 “(d) NOTICE.—A group health plan under this part
17 shall comply with the notice requirement under section
18 714(d) of the Employee Retirement Income Security Act
19 of 1974 with respect to the requirements of this section
20 as if such section applied to such plan.

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

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

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

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

8 “(4) has other predisposing factors that signifi-
9 cantly increase the risk of the individual contracting
10 that type of cancer.

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

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

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

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

24 “(2) provide to participants and beneficiaries,
25 within a reasonable period (as specified by the ap-

1 appropriate Secretary) before or after the date of sig-
2 nificant changes in the information described in sub-
3 section (b), information in printed form regarding
4 such significant changes; and

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

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

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

15 “(A) covered benefits, including benefit
16 limits and coverage exclusions;

17 “(B) cost sharing, such as deductibles, co-
18 insurance, and copayment amounts, including
19 any liability for balance billing, any maximum
20 limitations on out of pocket expenses, and the
21 maximum out of pocket costs for services that
22 are provided by nonparticipating providers or
23 that are furnished without meeting the applica-
24 ble utilization review requirements;

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

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

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

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

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

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

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

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

23 “(F) The name, address, and telephone
24 number of participating health care providers

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

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

10 (B) TECHNICAL AMENDMENT.—Section
11 2723(c) of the Public Health Service Act (42
12 U.S.C. 300gg–23(c)) is amended by striking
13 “section 2704” and inserting “sections 2704
14 and 2707”.

15 (2) ERISA AMENDMENTS.—

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

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

22 “(a) REQUIREMENT.—A group health plan, and a
23 health insurance issuer offering group health insurance
24 coverage, shall provide coverage and payment under the
25 plan or coverage for the following items and services under

1 terms and conditions that are no less favorable than the
2 terms and conditions applicable to other screening benefits
3 otherwise provided under the plan or coverage:

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 (e)) 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 provided coverage
23 for 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 “(b) PROHIBITIONS.—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 a provider to induce such provider to provide care
13 to an individual participant or beneficiary in a man-
14 ner 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 a procedure, examination, or test
19 described in subsection (a).

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

1 nate on any basis related to the coverage required
2 under this section.

3 “(d) NOTICE UNDER GROUP HEALTH PLAN.—The
4 imposition of the requirement of this section shall be treat-
5 ed as a material modification in the terms of the plan de-
6 scribed in section 102(a), for purposes of assuring notice
7 of such requirements under the plan; except that the sum-
8 mary description required to be provided under the last
9 sentence of section 104(b)(1) with respect to such modi-
10 fication shall be provided by not later than 60 days after
11 the first day of the first plan year in which such require-
12 ment apply.

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

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

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

21 “(3) has the presence of an appropriate recog-
22 nized gene marker that is identified as putting the
23 individual at a higher risk of developing that type of
24 cancer; or

1 “(4) has other predisposing factors that signifi-
2 cantly increase the risk of the individual contracting
3 that type of cancer.

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

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

8 “(a) DISCLOSURE REQUIREMENT.—A group health
9 plan, and health insurance issuer offering group health in-
10 surance coverage shall—

11 “(1) provide to participants and beneficiaries at
12 the time of initial coverage under the plan (or the
13 effective date of this section, in the case of individ-
14 uals who are participants or beneficiaries as of such
15 date), and at least annually thereafter, the informa-
16 tion described in subsection (b) in printed form;

17 “(2) provide to participants and beneficiaries,
18 within a reasonable period (as specified by the ap-
19 propriate Secretary) before or after the date of sig-
20 nificant changes in the information described in sub-
21 section (b), information in printed form regarding
22 such significant changes; and

23 “(3) upon request, make available to partici-
24 pants and beneficiaries, the applicable authority, and

1 prospective participants and beneficiaries, the infor-
2 mation described in subsection (b) in printed form.

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

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

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

11 “(B) cost sharing, such as deductibles, co-
12 insurance, and copayment amounts, including
13 any liability for balance billing, any maximum
14 limitations on out of pocket expenses, and the
15 maximum out of pocket costs for services that
16 are provided by nonparticipating providers or
17 that are furnished without meeting the applica-
18 ble utilization review requirements;

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

21 “(D) the extent to which a participant,
22 beneficiary, or enrollee may select from among
23 participating providers and the types of pro-
24 viders participating in the plan or issuer net-
25 work.

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

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

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

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

9 “(D) The procedures for participants,
10 beneficiaries, and enrollees to select, access, and
11 change participating primary and specialty pro-
12 viders.

13 “(E) The rights and procedures for obtain-
14 ing referrals (including standing referrals) to
15 participating and nonparticipating providers.

16 “(F) The name, address, and telephone
17 number of participating health care providers
18 and an indication of whether each such provider
19 is available to accept new patients.

20 “(G) How the plan or issuer addresses the
21 needs of participants, beneficiaries, and enroll-
22 ees and others who do not speak English or
23 who have other special communications needs in
24 accessing providers under the plan or coverage,

1 including the provision of information under
2 this subsection.”.

3 (B) TECHNICAL AMENDMENTS.—

4 (i) Section 731(c) of the Employee
5 Retirement Income Security Act of 1974
6 (29 U.S.C. 1191(c)) is amended by strik-
7 ing “section 711” and inserting “sections
8 711 and 714”.

9 (ii) Section 732(a) of the Employee
10 Retirement Income Security Act of 1974
11 (29 U.S.C. 1191a(a)) is amended by strik-
12 ing “section 711” and inserting “sections
13 711 and 714”.

14 (iii) The table of contents in section 1
15 of the Employee Retirement Income Secu-
16 rity Act of 1974 is amended by inserting
17 after the item relating to section 713 the
18 following new items:

“Sec. 714. Coverage of cancer screening.

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

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

22 (A) in the table of sections, by inserting
23 after the item relating to section 9812 the fol-
24 lowing new items:

“Sec. 9813. Coverage of cancer screening.
“Sec. 9814. Patient access to information.”;

1 and

2 (B) by inserting after section 9812 the fol-
3 lowing:

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

5 “(a) REQUIREMENT.—A group health plan shall pro-
6 vide coverage and payment under the plan for the fol-
7 lowing items and services under terms and conditions that
8 are no less favorable than the terms and conditions appli-
9 cable to other screening benefits otherwise provided under
10 the plan:

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

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

22 “(A)(i) is 40 years of age or older or (ii)
23 is at least 20 (but less than 40) years of age

1 and is at high risk of developing breast cancer,
2 an annual clinical breast examination; or

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

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

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

19 “(B) an annual pelvic examination.

20 “(4) COLORECTAL CANCER SCREENING PROCE-
21 DURES.—In the case of a participant or beneficiary
22 who is 50 years of age or older, or who is under 50
23 years of age and is at high risk of developing
24 colorectal cancer, the procedures described in section
25 1861(pp)(1) of the Social Security Act (42 U.S.C.

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

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

1 beneficiary, in consultation with the participant or
2 beneficiary.

3 “(b) PROHIBITIONS.—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 a provider to induce such provider to provide care
18 to an individual participant or beneficiary in a man-
19 ner 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 a procedure, examination, or test
24 described in subsection (a).

1 “(2) Nothing in this section shall be construed
2 as preventing a group health plan from imposing
3 deductibles, coinsurance, or other cost-sharing in re-
4 lation to benefits described in subsection (a) con-
5 sistent with such subsection, except that such coin-
6 surance or other cost-sharing shall not discriminate
7 on any basis related to the coverage required under
8 this section.

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

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

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

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

21 “(4) has other predisposing factors that signifi-
22 cantly increase the risk of the individual contracting
23 that type of cancer.

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

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

5 “(a) DISCLOSURE REQUIREMENT.—A group health
6 plan, and health insurance issuer offering group health in-
7 surance coverage shall—

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

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

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

24 “(b) INFORMATION PROVIDED.—The information de-
25 scribed in subsection (a) that shall be disclosed includes

1 the following, as such relates to cancer screening required
2 under section 9813(a):

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

5 “(A) covered benefits, including benefit
6 limits and coverage exclusions;

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

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

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

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

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

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

3 “(C) Any point-of-service option (including
4 any supplemental premium or cost-sharing for
5 such option).

6 “(D) The procedures for participants,
7 beneficiaries, and enrollees to select, access, and
8 change participating primary and specialty pro-
9 viders.

10 “(E) The rights and procedures for obtain-
11 ing referrals (including standing referrals) to
12 participating and nonparticipating providers.

13 “(F) The name, address, and telephone
14 number of participating health care providers
15 and an indication of whether each such provider
16 is available to accept new patients.

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

24 (b) INDIVIDUAL HEALTH INSURANCE.—

1 insurance coverage offered by a health insurance issuer
2 in connection with a group health plan in the small or
3 large group market to a participant or beneficiary in such
4 plan.”.

5 (2) TECHNICAL AMENDMENT.—Section
6 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2))
7 is amended by striking “section 2751” and inserting
8 “sections 2751 and 2753”.

9 (c) EFFECTIVE DATES.—

10 (1) GROUP HEALTH PLANS.—Subject to para-
11 graph (3), the amendments made by subsection (a)
12 shall apply with respect to group health plans for
13 plan years beginning on or after January 1, 2004.

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

19 (3) COLLECTIVE BARGAINING AGREEMENT.—In
20 the case of a group health plan maintained pursuant
21 to 1 or more collective bargaining agreements be-
22 tween employee representatives and 1 or more em-
23 ployers ratified before the date of enactment of this
24 Act, the amendments made to subsection (a) shall

1 not apply to plan years beginning before the later
2 of—

3 (A) the date on which the last collective
4 bargaining agreements relating to the plan ter-
5 minates (determined without regard to any ex-
6 tension thereof agreed to after the date of en-
7 actment of this Act), or

8 (B) January 1, 2004.

9 For purposes of subparagraph (A), any plan amend-
10 ment made pursuant to a collective bargaining
11 agreement relating to the plan which amends the
12 plan solely to conform to any requirement added by
13 subsection (a) shall not be treated as a termination
14 of such collective bargaining agreement.

15 (d) COORDINATED REGULATIONS.—Section 104(1)
16 of Health Insurance Portability and Accountability Act of
17 1996 (Public Law 104–191) is amended by striking “this
18 subtitle (and the amendments made by this subtitle and
19 section 401)” and inserting “the provisions of part 7 of
20 subtitle B of title I of the Employee Retirement Income
21 Security Act of 1974, the provisions of parts A and C of
22 title XXVII of the Public Health Service Act, and chapter
23 100 of the Internal Revenue Code of 1986”.

24 (e) MODIFICATION OF COVERAGE.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services may modify the coverage require-
3 ments for the amendments under this Act to allow
4 such requirements to incorporate and reflect new sci-
5 entific and technological advances regarding cancer
6 screening, practice pattern changes in such screen-
7 ing, or other updated medical practices regarding
8 such screening, such as the use of new tests or other
9 emerging technologies. Such modifications shall not
10 in any way diminish the coverage requirements listed
11 under this Act. Such modifications may be made on
12 the Secretary’s own initiative or upon petition to the
13 Secretary by an individual or organization.

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

18 (3) PETITIONS.—The Secretary of Health and
19 Human Services may issue requirements for the pe-
20 titioning process under paragraph (1), including re-
21 quirements that the petition be in writing and in-
22 clude scientific or medical bases for the modification
23 sought. Upon receipt of such a petition, the Sec-
24 retary shall respond to the petitioner and decide
25 whether to propose a regulation proposing a change

1 within 90 days of such receipt. If a regulation is re-
2 quired, the Secretary shall propose such regulation
3 within 6 months of such determination. The Sec-
4 retary shall provide the petitioner the reasons for
5 the decision of the Secretary. The Secretary may
6 make changes requested by a petitioner in whole or
7 in part.

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

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

11 **“§ 8915. Standards relating to coverage of cancer**
12 **screening and patient access to informa-**
13 **tion.**

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

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

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