106TH CONGRESS
1ST SESSION

S. 1641

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

SEPTEMBER 24, 1999

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

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Cancer Screening Coverage Act of 1999''.

SEC. 2. CANCER SCREENING COVERAGE.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

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

"SEC. 2707. COVERAGE OF CANCER SCREENING.

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

''(1) MAMMOGRAMS.—In the case of a female participant or beneficiary who is 40 years of age or older, or is under 40 years of age but is at high risk (as defined in subsection (e)) of developing breast cancer, an annual mammography (as defined in section 1861(jj) of the Social Security Act) conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

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

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

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

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

"(A) an annual diagnostic laboratory test (popularly known as a 'pap smear') consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and including an interpretation by a qualified health professional of the results of the test; and

"(B) an annual pelvic examination.

"(4) COLORECTAL CANCER SCREENING PROCEDURES.—In the case of a participant or beneficiary who is 50 years of age or older, or who is under 50 years of age and is at high risk of developing

colorectal cancer, the procedures described in section 1861(pp)(1) of the Social Security Act (42 U.S.C. 1395x(pp)(1)) or section 4104(a)(2) of the Balanced Budget Act of 1997 (111 Stat. 362), shall be furnished to the individual for the purpose of early detection of colorectal cancer. The group health plan or health insurance issuer shall provide coverage for the method and frequency of colorectal cancer screening determined to be appropriate by a health care provider treating such participant or beneficiary, in consultation with the participant or beneficiary.

''(5) PROSTATE CANCER SCREENING.—In the case of a participant or beneficiary who is 50 years of age or older, or who is a male who is at high risk for prostate cancer (such as an African American or a male who has a history of prostate cancer in close family members), an annual test consisting of any (or all) of the procedures described in section 1861(oo)(2) of Social Security Act (42 U.S.C. 1395x(oo)(2)) provided for the purpose of early detection of prostate cancer.

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

such frequency, as the Secretary determines to be appropriate, in consultation with appropriate organizations and agencies, for the diagnosis or detection of cancer.

''(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

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

''(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care to an individual participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to a provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

''(c) RULES OF CONSTRUCTION.—

''(1) Nothing in this section shall be construed to require an individual who is a participant or beneficiary to undergo a procedure, examination, or test described in subsection (a).

''(2) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits described in subsection (a) consistent with such subsection, except that such coinsurance or other cost-sharing shall not discriminate on any basis related to the coverage required under this section.

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

''(e) HIGH RISK DEFINED.—For purposes of this section, an individual is considered to be at 'high risk' of developing a particular type of cancer if, under guidelines developed or recognized by the Secretary based upon scientific evidence, the individual—

''(1) has one or more close family members who have developed that type of cancer;

''(2) has previously had that type of cancer;

''(3) has the presence of an appropriate recognized gene marker that is identified as putting the individual at a higher risk of developing that type of cancer; or

''(4) has other predisposing factors that significantly increases the risk of the individual contracting that type of cancer.

For purposes of this subsection, the term 'type of cancer' includes other types of cancer that the Secretary recognizes as closely related for purposes of establishing risk.''.

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

(2) ERISA AMENDMENTS.—

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

''SEC. 714. COVERAGE OF CANCER SCREENING.

''(a) REQUIREMENT.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide coverage and payment under the

plan or coverage for the following items and services under terms and conditions that are no less favorable than the terms and conditions applicable to other screening benefits otherwise provided under the plan or coverage:

''(1) MAMMOGRAMS.—In the case of a female participant or beneficiary who is 40 years of age or older, or is under 40 years of age but is at high risk (as defined in subsection (e)) of developing breast cancer, an annual mammography (as defined in section 1861(jj) of the Social Security Act) conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

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

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

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

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

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

"(A) an annual diagnostic laboratory test (popularly known as a 'pap smear') consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and including an interpretation by a qualified health professional of the results of the test; and

"(B) an annual pelvic examination.

"(4) COLORECTAL CANCER SCREENING PROCEDURES.—In the case of a participant or beneficiary who is 50 years of age or older, or who is under 50 years of age and is at high risk of developing colorectal cancer, the procedures described in section 1861(pp)(1) of the Social Security Act (42 U.S.C. 1395x(pp)(1)) or section 4104(a)(2) of the Balanced Budget Act of 1997 (111 Stat. 362), shall be furnished to the individual for the purpose of early detection of colorectal cancer. The group health plan or health insurance issuer shall provided coverage for the method and frequency of colorectal cancer screening determined to be appropriate by a health care provider treating such participant or bene-

ficiary, in consultation with the participant or beneficiary.

''(5) PROSTATE CANCER SCREENING.—In the case of a participant or beneficiary who is 50 years of age or older, or who is a male who is at high risk for prostate cancer (such as an African American or a male who has a history of prostate cancer in close family members), an annual test consisting of any (or all) of the procedures described in section 1861(oo)(2) of Social Security Act (42 U.S.C. 1395x(oo)(2)) provided for the purpose of early detection of prostate cancer.

''(6) OTHER TESTS AND PROCEDURES.—Such other tests or procedures for the detection of cancer, and modifications to the tests and procedures, with such frequency, as the Secretary determines to be appropriate, in consultation with appropriate organizations and agencies, for the diagnosis or detection of cancer.

''(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under

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

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

''(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care to an individual participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to a provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

''(c) RULES OF CONSTRUCTION.—

''(1) Nothing in this section shall be construed to require an individual who is a participant or beneficiary to undergo a procedure, examination, or test described in subsection (a).

''(2) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits described in subsection (a) consistent with such subsection, except that such coinsurance or other cost-sharing shall not discrimi-

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

''(d) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirement of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirement apply.

''(e) HIGH RISK DEFINED.—For purposes of this section, an individual is considered to be at 'high risk' of developing a particular type of cancer if, under guidelines developed or recognized by the Secretary based upon scientific evidence, the individual—

''(1) has one or more close family members who have developed that type of cancer;

''(2) has previously had that type of cancer;

''(3) has the presence of an appropriate recognized gene marker that is identified as putting the individual at a higher risk of developing that type of cancer; or

''(4) has other predisposing factors that significantly increases the risk of the individual contracting that type of cancer.

For purposes of this subsection, the term 'type of cancer' includes other types of cancer that the Secretary recognizes as closely related for purposes of establishing risk.''.

(B) TECHNICAL AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Coverage of cancer screening.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(A) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Coverage of cancer screening.''; and

(B) by inserting after section 9812 the following:

''SEC. 9813. COVERAGE OF CANCER SCREENING.

''(a) REQUIREMENT.—A group health plan shall provide coverage and payment under the plan for the following items and services under terms and conditions that are no less favorable than the terms and conditions applicable to other screening benefits otherwise provided under the plan:

''(1) MAMMOGRAMS.—In the case of a female participant or beneficiary who is 40 years of age or older, or is under 40 years of age but is at high risk (as defined in subsection (d)) of developing breast cancer, an annual mammography (as defined in section 1861(jj) of the Social Security Act) conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

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

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

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

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

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

"(A) an annual diagnostic laboratory test (popularly known as a 'pap smear') consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and including an interpretation by a qualified health professional of the results of the test; and

"(B) an annual pelvic examination.

"(4) COLORECTAL CANCER SCREENING PROCEDURES.—In the case of a participant or beneficiary who is 50 years of age or older, or who is under 50 years of age and is at high risk of developing colorectal cancer, the procedures described in section 1861(pp)(1) of the Social Security Act (42 U.S.C.

1395x(pp)(1)) or section 4104(a)(2) of the Balanced Budget Act of 1997 (111 Stat. 362), shall be furnished to the individual for the purpose of early detection of colorectal cancer. The group health plan or health insurance issuer shall provide coverage for the method and frequency of colorectal cancer screening determined to be appropriate by a health care provider treating such participant or beneficiary, in consultation with the participant or beneficiary.

''(5) PROSTATE CANCER SCREENING.—In the case of a participant or beneficiary who is 50 years of age or older, or who is a male who is at high risk for prostate cancer (such as an African American or a male who has a history of prostate cancer in close family members), an annual test consisting of any (or all) of the procedures described in section 1861(oo)(2) of Social Security Act (42 U.S.C. 1395x(oo)(2)) provided for the purpose of early detection of prostate cancer.

''(6) OTHER TESTS AND PROCEDURES.—Such other tests or procedures for the detection of cancer, and modifications to the tests and procedures, with such frequency, as the Secretary determines to be appropriate, in consultation with appropriate organi-

zations and agencies, for the diagnosis or detection of cancer.

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

''(1) deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

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

''(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care to an individual participant or beneficiary in accordance with this section; or

''(4) provide incentives (monetary or otherwise) to a provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

''(c) RULES OF CONSTRUCTION.—

''(1) Nothing in this section shall be construed to require an individual who is a participant or beneficiary to undergo a procedure, examination, or test described in subsection (a).

''(2) Nothing in this section shall be construed as preventing a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits described in subsection (a) consistent with such subsection, except that such coinsurance or other cost-sharing shall not discriminate on any basis related to the coverage required under this section.

''(d) HIGH RISK DEFINED.—For purposes of this section, an individual is considered to be at 'high risk' of developing a particular type of cancer if, under guidelines developed or recognized by the Secretary based upon scientific evidence, the individual—

''(1) has one or more close family members who have developed that type of cancer;

''(2) has previously had that type of cancer;

''(3) has the presence of an appropriate recognized gene marker that is identified as putting the individual at a higher risk of developing that type of cancer; or

''(4) has other predisposing factors that significantly increases the risk of the individual contracting that type of cancer.

For purposes of this subsection, the term 'type of cancer' includes other types of cancer that the Secretary recognizes as closely related for purposes of establishing risk.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

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

''SEC. 2753. STANDARD RELATING PATIENT FREEDOM OF CHOICE.

''(a) IN GENERAL.—The provisions of section 2707 (other than subsection (d)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market with respect to an enrollee under such coverage in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market to a participant or beneficiary in such plan.

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

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

(c) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS.—Subject to paragraph (3), the amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

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

(3) COLLECTIVE BARGAINING AGREEMENT.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made to subsection (a) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any ex-

tension thereof agreed to after the date of enactment of this Act), or

(B) January 1, 2000.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

(e) MODIFICATION OF COVERAGE.—

(1) IN GENERAL.—The Secretary of Health and Human Services may, by regulation, modify the coverage requirements applicable pursuant to the amendments made by this Act to reflect changes in medical practice or new scientific knowledge, on the

Secretary's own initiative or upon petition of an individual or organization.

(2) CONSULTATION.—In modifying coverage requirements under paragraph (1), the Secretary of Health and Human Services shall consult with appropriate organizations, experts, and agencies.

(3) PETITIONS.—The Secretary of Health and Human Services may issue requirements for the petitioning process under paragraph (1), including requirements that the petition be in writing and include scientific or medical bases for the modification sought. Upon receipt of such a petition, the Secretary shall respond to the petitioner and decide whether to propose a regulation proposing a change within 90 days of such receipt. If a regulation is required, the Secretary shall propose such regulation within 6 months of such determination. The Secretary shall provide the petitioner the reasons for the decision of the Secretary. The Secretary may make changes requested by a petitioner in whole or in part.

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