I

110TH CONGRESS
1ST SESSION

H. R. 3060

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

IN THE HOUSE OF REPRESENTATIVES

JULY 17, 2007

Mr. BOREN (for himself and Mr. HALL of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

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 ''Colorectal Cancer Screening and Detection Coverage Act of 2007''.

SEC. 2. COVERAGE OF COLORECTAL CANCER SCREENING.

(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 COLORECTAL CANCER SCREENING.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide coverage under the plan or coverage, respectively, for colorectal cancer screening for any participant or beneficiary who is 50 years of age or older, or is an individual who is at high risk for colorectal cancer (as defined in section 1861(pp)(2) of the Social Security Act (42 U.S.C. 1395x(pp)(2)), 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, respectively.

"(2) COLORECTAL CANCER SCREENING DEFINED.—For purposes of this section, the term 'colorectal cancer screening' means procedures that—

"(A) are deemed appropriate by a physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) treating the participant or beneficiary, in consultation with the participant or beneficiary;

"(B) are—

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

"(ii) specified by the Secretary for the detection of colorectal cancer, based upon the recommendations of appropriate organizations with special expertise in the field of colorectal cancer, including the American Cancer Society and the American College of Gastroenterology; or

"(iii) specified by the Secretary, based upon new scientific knowledge, technological advances, or other updated medical

practices with respect to detection of colorectal cancer; and

"(C) are performed at a frequency not greater than that—

"(i) described for such method in section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) or section 410.37 of title 42, Code of Federal Regulations; or

"(ii) specified by the Secretary for such method, if the Secretary finds, based upon new scientific knowledge, technological advances, or other updated medical practices and consistent with the recommendations of appropriate organizations with special expertise in the field of colorectal cancer, that a different frequency would not adversely affect the effectiveness of such screening.

"(b) PROTECTIONS.—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 an attending 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 colorectal cancer screening.

''(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 colorectal cancer screening under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing shall not dis-

criminate 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) DISCLOSURE REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and health insurance issuer offering group health insurance coverage shall—

''(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in paragraph (2);

''(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in paragraph (2), information regarding such significant changes; and

"(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in paragraph (2).

"(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph, with respect to colorectal cancer screening, is the following:

"(A) BENEFITS.—Benefits offered under the plan or coverage, including—

"(i) covered benefits, including benefit limits and coverage exclusions;

"(ii) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

"(iii) the extent to which benefits may be obtained from nonparticipating providers; and

''(iv) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network.

''(B) ACCESS.—A description of the following:

''(i) The number, mix, and distribution of providers under the plan or coverage.

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

''(iii) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(iv) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

''(v) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(vi) The name, address, and telephone number of participating health care

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

''(vii) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information under this paragraph.''.

(B) Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2707''.

(2) ERISA AMENDMENTS.—

(A) Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. COVERAGE OF COLORECTAL CANCER SCREENING.

''(a) REQUIREMENT.—

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

ance coverage, shall provide coverage under the plan or coverage, respectively, for colorectal cancer screening for any participant or beneficiary who is 50 years of age or older, or is an individual who is at high risk for colorectal cancer (as defined in section 1861(pp)(2) of the Social Security Act (42 U.S.C. 1395x(pp)(2)), 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, respectively.

''(2) COLORECTAL CANCER SCREENING DEFINED.—For purposes of this section, the term 'colorectal cancer screening' means procedures that—

''(A) are deemed appropriate by a physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) treating the participant or beneficiary, in consultation with the participant or beneficiary;

''(B) are—

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

''(ii) specified by the Secretary for the detection of colorectal cancer, based upon the recommendations of appropriate organizations with special expertise in the field of colorectal cancer, including the American Cancer Society and the American College of Gastroenterology; or

''(iii) specified by the Secretary, based upon new scientific knowledge, technological advances, or other updated medical practices with respect to detection of colorectal cancer; and

''(C) are performed at a frequency not greater than that—

''(i) described for such method in section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) or section 410.37 of title 42, Code of Federal Regulations; or

''(ii) specified by the Secretary for such method, if the Secretary finds, based upon new scientific knowledge, technological advances, or other updated medical practices and consistent with the recommendations of appropriate organizations with special expertise in the field of

colorectal cancer, that a different frequency would not adversely affect the effectiveness of such screening.

''(b) PROTECTIONS.—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 an attending 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 colorectal cancer screening.

''(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 colorectal cancer screening under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing shall not discriminate on any basis related to the coverage required under this section.

''(d) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the fourth 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 requirements apply.

''(e) DISCLOSURE REQUIREMENT.—

''(1) IN GENERAL.—A group health plan, and health insurance issuer offering group health insurance coverage shall—

''(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in paragraph (2);

''(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in paragraph (2), information regarding such significant changes; and

''(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph, with respect to colorectal cancer screening, is the following:

''(A) BENEFITS.—Benefits offered under the plan or coverage, including—

''(i) covered benefits, including benefit limits and coverage exclusions;

''(ii) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

''(iii) the extent to which benefits may be obtained from nonparticipating providers; and

''(iv) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network.

''(B) ACCESS.—A description of the following:

''(i) The number, mix, and distribution of providers under the plan or coverage.

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

''(iii) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(iv) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

''(v) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(vi) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

''(vii) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special commu-

nications needs in accessing providers under the plan or coverage, including the provision of information under this paragraph.''.

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

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

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

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

(3) INTERNAL REVENUE CODE AMENDMENTS.—

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

''SEC. 9813. COVERAGE OF COLORECTAL CANCER SCREENING.

''(a) REQUIREMENT.—

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

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

''(2) COLORECTAL CANCER SCREENING DEFINED.—For purposes of this section, the term 'colorectal cancer screening' means procedures that—

''(A) are deemed appropriate by a physician (as defined in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))) treating the participant or beneficiary, in consultation with the participant or beneficiary;

''(B) are—

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

''(ii) specified by the Secretary of Health and Human Services for the detection of colorectal cancer, based upon the recommendations of appropriate organiza-

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

''(iii) specified by the Secretary of Health and Human Services, based upon new scientific knowledge, technological advances, or other updated medical practices with respect to detection of colorectal cancer; and

''(C) are performed at a frequency not greater than that—

''(i) described for such method in section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) or section 410.37 of title 42, Code of Federal Regulations; or

''(ii) specified by the Secretary of Health and Human Services for such method, if such Secretary finds, based upon new scientific knowledge, technological advances, or other updated medical practices and consistent with the recommendations of appropriate organizations with special expertise in the field of colorectal cancer, that a different fre-

quency would not adversely affect the effectiveness of such screening.

''(b) PROTECTIONS.—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 an attending 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 colorectal cancer screening.

''(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 colorectal cancer screening under the plan, except that such coinsurance or other cost-sharing shall not discriminate on any basis related to the coverage required under this section.

''(d) DISCLOSURE REQUIREMENT.—

''(1) IN GENERAL.—A group health plan shall—

''(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in paragraph (2);

''(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in paragraph (2), information regarding such significant changes; and

''(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and bene-

ficiaries, the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph, with respect to colorectal cancer screening, is the following:

''(A) BENEFITS.—Benefits offered under the plan, including—

''(i) covered benefits, including benefit limits and coverage exclusions;

''(ii) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

''(iii) the extent to which benefits may be obtained from nonparticipating providers; and

''(iv) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and

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

''(B) ACCESS.—A description of the following:

''(i) The number, mix, and distribution of providers under the plan.

''(ii) Out-of-network coverage (if any) provided by the plan.

''(iii) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

''(iv) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

''(v) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

''(vi) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

''(vii) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan, including the provision of information under this paragraph.''.

(B) The table of sections of such subchapter of such Code is amended by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Coverage of colorectal cancer screening.''.

(C) Section 4980D(d)(1) of such Code is amended by striking ''section 9811'' and inserting ''sections 9811 and 9813''.

(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 the following new section:

''SEC. 2753. COVERAGE OF COLORECTAL CANCER SCREENING.

''(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 in the same manner as it applies to health insurance coverage offered by a health insurance issuer

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

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

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

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

(d) EFFECTIVE DATES.—

(1) GROUP HEALTH PLANS AND HEALTH BENEFIT PLANS.—The amendments made by subsections (a) and (c) shall apply with respect to group health plans (and health insurance coverage offered in connection with group health plans) and health benefit

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

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

(e) COORDINATION OF ADMINISTRATION.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this section (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

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