I

111TH CONGRESS
2D SESSION

H. R. 4563

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

FEBRUARY 2, 2010

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 Labor, Ways and Means, 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 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.

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 2009''.

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:

''SEC. 2708. 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.

''(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 male participant or beneficiary who is 50 years of age or older, or who is younger than 50 years of age and is at high risk for prostate cancer (including African-American men or a male who has a history of prostate cancer in 1 or more first degree family members), the procedures described in section 1861(oo)(2) of Social Security Act (42 U.S.C.

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

''(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 1 or more first degree 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 increase 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.

''SEC. 2709. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—A group health plan, and health insurance issuer offering group health insurance coverage shall—

''(1) 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 subsection (b) in printed form;

''(2) 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 subsection (b), information in printed form regarding such significant changes; and

''(3) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) in printed form.

''(b) INFORMATION PROVIDED.—The information described in subsection (a) that shall be disclosed includes the following, as such relates to cancer screening required under section 2708(a):

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

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

''(B) 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;

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

''(D) 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.

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

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

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

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

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

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

''(F) 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.

''(G) 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 subsection.''.

(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 2708''.

(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. 715. 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 beneficiary, in consultation with the participant or beneficiary.

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

''(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 discriminate 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), 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 1 or more first degree 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 increase 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.

''SEC. 716. PATIENT ACCESS TO INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—A group health plan, and health insurance issuer offering group health insurance coverage shall—

''(1) 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 subsection (b) in printed form;

''(2) 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 subsection (b), information in printed form regarding such significant changes; and

''(3) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) in printed form.

''(b) INFORMATION PROVIDED.—The information described in subsection (a) that shall be disclosed includes the following, as such relates to cancer screening required under section 715(a):

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

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

''(B) 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;

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

''(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of pro-

viders participating in the plan or issuer network.

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

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

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

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

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

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

''(F) 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.

''(G) 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 subsection.''.

(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 715''.

(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 715''.

(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 714 the following new items:

''Sec. 715. Coverage of cancer screening.
''Sec. 716. Patient access to information.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986

is amended by inserting after section 9813 the following:

"SEC. 9814. 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 fur-

nished 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 male participant or beneficiary who is 50 years of age or older, or who is younger than 50 years of age and is at high risk for prostate cancer (including African-American men or a male who has a history of prostate cancer in 1 or more first degree family members), the procedures described in section 1861(oo)(2) of Social Security Act (42 U.S.C. 1395x(oo)(2)) shall be furnished to the individual for the early detection of prostate cancer. The group health plan or health insurance issuer shall provide coverage for the method and frequency of prostate cancer screening determined to be appropriate by a health care provider treating such participant or beneficiary, in consultation with the participant or beneficiary.

''(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) con-

sistent 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 1 or more first degree 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 increase 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.

"SEC. 9815. PATIENT ACCESS TO INFORMATION.

"(a) DISCLOSURE REQUIREMENT.—A group health plan, and health insurance issuer offering group health insurance coverage shall—

"(1) 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 subsection (b) in printed form;

"(2) 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 subsection (b), information in printed form regarding such significant changes; and

"(3) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) in printed form.

"(b) INFORMATION PROVIDED.—The information described in subsection (a) that shall be disclosed includes the following, as such relates to cancer screening required under section 9814(a):

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

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

''(B) 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;

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

''(D) 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.

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

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

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

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

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

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

''(F) 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.

''(G) 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 subsection.''.

(B) CLERICAL AMENDMENT.—The table of sections of chapter is amended by inserting after the item relating to section 9812 the following new items:

''Sec. 9814. Coverage of cancer screening.
''Sec. 9815. Patient access to information.''.

(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. 2754. STANDARD RELATING PATIENT FREEDOM OF CHOICE.

''(a) IN GENERAL.—The provisions of section 2708 (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.

"SEC. 2755. PATIENT ACCESS TO INFORMATION.

''The provisions of section 2709 shall apply 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.''.

(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 2754''.

(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, 2010.

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

(B) January 1, 2010.

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 (Public Law 104–191) 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 modify the coverage requirements for the amendments under this Act to allow such requirements to incorporate and reflect new scientific and technological advances regarding cancer screening, practice pattern changes in such screening, or other updated medical practices regarding such screening, such as the use of new tests or other emerging technologies. Such modifications shall not in any way diminish the coverage requirements listed under this Act. Such modifications may be made on the Secretary's own initiative or upon petition to the Secretary by 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.

SEC. 3. APPLICATION TO OTHER HEALTH CARE COVERAGE.

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

"§ 8915. Standards relating to coverage of cancer screening and patient access to information

''(a) The provisions of sections 2708 and 2709 of the Public Health Service Act shall apply to the provision of items and services under this chapter.

''(b) Nothing in this section or section 2708(c) of the Public Health Service Act shall be construed as authorizing a health insurance issuer or entity to impose cost sharing with respect to the coverage or benefits required to be provided under section 2708 of the Public Health Service Act that is inconsistent with the cost sharing that is otherwise permitted under this chapter.''.

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