

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.

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## 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.

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 2009”.

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. 2708. 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

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

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

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

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

1 “(B) an annual pelvic examination.

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

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

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

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

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

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

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

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

5           “(c) RULES OF CONSTRUCTION.—

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

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

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

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

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

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

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

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

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

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

16 **“SEC. 2709. PATIENT ACCESS TO INFORMATION.**

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

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

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

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

11          “(b) INFORMATION PROVIDED.—The information de-  
12          scribed in subsection (a) that shall be disclosed includes  
13          the following, as such relates to cancer screening required  
14          under section 2708(a):

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

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

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



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

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

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

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

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

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

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

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

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

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

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

12           (B) TECHNICAL AMENDMENT.—Section  
 13          2723(c) of the Public Health Service Act (42  
 14          U.S.C. 300gg–23(c)) is amended by striking  
 15          “section 2704” and inserting “sections 2704  
 16          and 2708”.

17          (2) ERISA AMENDMENTS.—

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

23       **“SEC. 715. COVERAGE OF CANCER SCREENING.**

24           “(a) REQUIREMENT.—A group health plan, and a  
 25          health insurance issuer offering group health insurance

1 coverage, shall provide coverage and payment under the  
2 plan or coverage for the following items and services under  
3 terms and conditions that are no less favorable than the  
4 terms and conditions applicable to other screening benefits  
5 otherwise provided under the plan or coverage:

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

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

17                   “(A)(i) is 40 years of age or older; or

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

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

1           “(3) PAP TESTS AND PELVIC EXAMINATIONS.—

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

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

13                   “(B) an annual pelvic examination.

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

1 screening determined to be appropriate by a health  
2 care provider treating such participant or bene-  
3 ficiary, in consultation with the participant or bene-  
4 ficiary.

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

21 “(b) PROHIBITIONS.—A group health plan, and a  
22 health insurance issuer offering group health insurance  
23 coverage in connection with a group health plan, may  
24 not—

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

5           “(2) provide monetary payments or rebates to  
6           individuals to encourage such individuals to accept  
7           less than the minimum protections available under  
8           this section;

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

13          “(4) provide incentives (monetary or otherwise)  
14          to a provider to induce such provider to provide care  
15          to an individual participant or beneficiary in a man-  
16          ner inconsistent with this section.

17          “(c) RULES OF CONSTRUCTION.—

18                 “(1) Nothing in this section shall be construed  
19                 to require an individual who is a participant or bene-  
20                 ficiary to undergo a procedure, examination, or test  
21                 described in subsection (a).

22                 “(2) Nothing in this section shall be construed  
23                 as preventing a group health plan or issuer from im-  
24                 posing deductibles, coinsurance, or other cost-shar-  
25                 ing in relation to benefits described in subsection (a)

1 consistent with such subsection, except that such co-  
2 insurance or other cost-sharing shall not discrimi-  
3 nate on any basis related to the coverage required  
4 under this section.

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

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

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

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

23 “(3) has the presence of an appropriate recog-  
24 nized gene marker that is identified as putting the

1 individual at a higher risk of developing that type of  
 2 cancer; or

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

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

9 **“SEC. 716. PATIENT ACCESS TO INFORMATION.**

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

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

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



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

5           “(b) INFORMATION PROVIDED.—The information de-  
6           scribed in subsection (a) that shall be disclosed includes  
7           the following, as such relates to cancer screening required  
8           under section 715(a):

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

11               “(A) covered benefits, including benefit  
12               limits and coverage exclusions;

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

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

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

1           viders participating in the plan or issuer net-  
2           work.

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

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

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

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

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

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

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

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

1           accessing providers under the plan or coverage,  
 2           including the provision of information under  
 3           this subsection.”.

4           (B) TECHNICAL AMENDMENTS.—

5           (i) Section 731(c) of the Employee  
 6           Retirement Income Security Act of 1974  
 7           (29 U.S.C. 1191(c)) is amended by strik-  
 8           ing “section 711” and inserting “sections  
 9           711 and 715”.

10          (ii) Section 732(a) of the Employee  
 11          Retirement Income Security Act of 1974  
 12          (29 U.S.C. 1191a(a)) is amended by strik-  
 13          ing “section 711” and inserting “sections  
 14          711 and 715”.

15          (iii) The table of contents in section 1  
 16          of the Employee Retirement Income Secu-  
 17          rity Act of 1974 is amended by inserting  
 18          after the item relating to section 714 the  
 19          following new items:

“Sec. 715. Coverage of cancer screening.

“Sec. 716. Patient access to information.”.

20          (3) INTERNAL REVENUE CODE AMEND-  
 21          MENTS.—

22          (A) IN GENERAL.—Subchapter B of chap-  
 23          ter 100 of the Internal Revenue Code of 1986

1 is amended by inserting after section 9813 the  
2 following:

3 **“SEC. 9814. COVERAGE OF CANCER SCREENING.**

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

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

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

21 “(A)(i) is 40 years of age or older; or

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

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

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

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

17          “(B) an annual pelvic examination.

18          “(4) COLORECTAL CANCER SCREENING PROCE-  
19          DURES.—In the case of a participant or beneficiary  
20          who is 50 years of age or older, or who is under 50  
21          years of age and is at high risk of developing  
22          colorectal cancer, the procedures described in section  
23          1861(pp)(1) of the Social Security Act (42 U.S.C.  
24          1395x(pp)(1)) or section 4104(a)(2) of the Balanced  
25          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           “(1) deny to an individual eligibility, or contin-  
2           ued eligibility, to enroll or to renew coverage under  
3           the terms of the plan, solely for the purpose of  
4           avoiding the requirements of this section;

5           “(2) provide monetary payments or rebates to  
6           individuals to encourage such individuals to accept  
7           less than the minimum protections available under  
8           this section;

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

13          “(4) provide incentives (monetary or otherwise)  
14          to a provider to induce such provider to provide care  
15          to an individual participant or beneficiary in a man-  
16          ner inconsistent with this section.

17          “(c) RULES OF CONSTRUCTION.—

18               “(1) Nothing in this section shall be construed  
19               to require an individual who is a participant or bene-  
20               ficiary to undergo a procedure, examination, or test  
21               described in subsection (a).

22               “(2) Nothing in this section shall be construed  
23               as preventing a group health plan from imposing  
24               deductibles, coinsurance, or other cost-sharing in re-  
25               lation to benefits described in subsection (a) con-

1       sistent with such subsection, except that such coin-  
2       surance or other cost-sharing shall not discriminate  
3       on any basis related to the coverage required under  
4       this section.

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

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

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

13           “(3) has the presence of an appropriate recog-  
14       nized gene marker that is identified as putting the  
15       individual at a higher risk of developing that type of  
16       cancer; or

17           “(4) has other predisposing factors that signifi-  
18       cantly increase the risk of the individual contracting  
19       that type of cancer.

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



1 **“SEC. 9815. PATIENT ACCESS TO INFORMATION.**

2 “(a) DISCLOSURE REQUIREMENT.—A group health  
3 plan, and health insurance issuer offering group health in-  
4 surance coverage shall—

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

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

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

21 “(b) INFORMATION PROVIDED.—The information de-  
22 scribed in subsection (a) that shall be disclosed includes  
23 the following, as such relates to cancer screening required  
24 under section 9814(a):

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

1           “(A) covered benefits, including benefit  
2 limits and coverage exclusions;

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

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

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

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

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

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

23           “(C) Any point-of-service option (including  
24 any supplemental premium or cost-sharing for  
25 such option).

1           “(D) The procedures for participants,  
2           beneficiaries, and enrollees to select, access, and  
3           change participating primary and specialty pro-  
4           viders.

5           “(E) The rights and procedures for obtain-  
6           ing referrals (including standing referrals) to  
7           participating and nonparticipating providers.

8           “(F) The name, address, and telephone  
9           number of participating health care providers  
10          and an indication of whether each such provider  
11          is available to accept new patients.

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

19          (B) CLERICAL AMENDMENT.—The table of  
20          sections of chapter is amended by inserting  
21          after the item relating to section 9812 the fol-  
22          lowing new items:

“Sec. 9814. Coverage of cancer screening.

“Sec. 9815. Patient access to information.”.

23          (b) INDIVIDUAL HEALTH INSURANCE.—

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

5       **“SEC. 2754. STANDARD RELATING PATIENT FREEDOM OF**  
6                               **CHOICE.**

7           “(a) IN GENERAL.—The provisions of section 2708  
8       (other than subsection (d)) shall apply to health insurance  
9       coverage offered by a health insurance issuer in the indi-  
10      vidual market with respect to an enrollee under such cov-  
11      erage in the same manner as they apply to health insur-  
12      ance coverage offered by a health insurance issuer in con-  
13      nection with a group health plan in the small or large  
14      group market to a participant or beneficiary in such plan.

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

21       **“SEC. 2755. PATIENT ACCESS TO INFORMATION.**

22          ““The provisions of section 2709 shall apply health in-  
23      surance coverage offered by a health insurance issuer in  
24      the individual market with respect to an enrollee under  
25      such coverage in the same manner as they apply to health

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 2754”.

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, 2010.

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, 2010.

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 2708 and 2709 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 2708(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 2708 of the Public Health  
 22   Service Act that is inconsistent with the cost sharing that  
 23   is otherwise permitted under this chapter.”.

○