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.

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

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

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

"(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-

1 nished to the individual for the purpose of early de-
2 tection of colorectal cancer. The group health plan
3 or health insurance issuer shall provide coverage for
4 the method and frequency of colorectal cancer
5 screening determined to be appropriate by a health
6 care provider treating such participant or bene-
7 ficiary, in consultation with the participant or bene-
8 ficiary.

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

25 ''(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.

"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—

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, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

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

8 "(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.

12 "(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.".

19 (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.".

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

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 (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.".

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