TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 136 entitled "An act relating to cost-sharing for preventive services" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 4100a is amended to read:

§ 4100a. MAMMOGRAMS; COVERAGE REQUIRED

(a) Insurers shall provide coverage for screening by ~~low-dose~~ mammography for the presence of occult breast cancer, as provided by this subchapter. Benefits provided shall cover the full cost of the mammography service~~, subject to a co-payment no greater than the co-payment applicable to care or services provided by a primary care physician under the insured's policy, provided that no co-payment shall exceed $25.00. Mammography services~~ and shall not be subject to any co-payment, deductible, ~~or~~ coinsurance ~~requirements~~, or other cost-sharing requirement or additional charge.

(b) For females 40 years or older, coverage shall be provided for an annual screening. For females less than 40 years of age, coverage for screening shall be provided upon recommendation of a health care provider.

(c) After January 1, 1994, this section shall apply only to screening procedures conducted by test facilities accredited by the American College of Radiologists.

(d) For purposes of this subchapter:

(1) "Insurer" means any insurance company which provides health insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and medical service corporations, and health maintenance organizations. The term does not apply to coverage for specified disease or other limited benefit coverage.

(2) ~~"Low-dose mammography"~~ "Mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes. ~~The average radiation dose to the breast shall be the lowest dose generally recognized by competent medical authority to be practicable for yielding acceptable radiographic images.~~

(3) "Screening" includes the ~~low-dose~~ mammography test procedure and a qualified physician's interpretation of the results of the procedure, including additional views and interpretation as needed.

Sec. 2. 8 V.S.A. § 4100g is amended to read:

§ 4100g. COLORECTAL CANCER SCREENING, COVERAGE REQUIRED

(a) For purposes of this section:

(1) "Colonoscopy" means a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps, biopsy, or both.

(2) "Insurer" means insurance companies that provide health insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and medical services corporations, and health maintenance organizations. The term does not apply to coverage for specified disease or other limited benefit coverage.

(b) Insurers shall provide coverage for colorectal cancer screening, including:

(1) Providing an insured 50 years of age or older with the option of:

(A) Annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or

(B) One colonoscopy every 10 years.

(2) For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

(c) For the purposes of subdivision (b)(2) of this section, an individual is at high risk for colorectal cancer if the individual has:

(1) A family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;

(2) A prior occurrence of colorectal cancer or precursor polyps;

(3) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or

(4) Other predisposing factors as determined by the individual's treating physician.

(d) ~~Benefits provided shall cover the colorectal cancer screening subject to a co-payment no greater than the co-payment applicable to care or services provided by a primary care physician under the insured's policy, provided that no co-payment shall exceed $100.00 for services performed under contract with the insurer.~~ Colorectal cancer screening services performed under contract with the insurer ~~also~~ shall not be subject to any co-payment, deductible, ~~or~~ coinsurance ~~requirements~~, or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

(1) removal of tissue or other matter;

(2) laboratory services;

(3) physician services;

(4) facility use; and

(5) anesthesia.

(e) ~~If determined to be permitted by Centers for Medicare and Medicaid Services, for a patient covered under the Medicare program, the patient's out-of-pocket expenditure for a colorectal cancer screening shall not exceed $100.00, with the hospital or other health care facility where the screening is performed absorbing the difference between the Medicare payment and the Medicare negotiated rate for the screening.~~ [Deleted.]

Sec. 3. STATUTORY CONSTRUCTION; LEGISLATIVE INTENT

The express enumeration of the services associated with a procedure or test for colorectal cancer in 8 V.S.A. § 4100g(d) shall not be construed to suggest that those services should not also be covered as part of any other procedure or test, even if the provisions of law applicable to the other procedure or test do not expressly list the associated services in the same manner or to the same extent that they are enumerated in 8 V.S.A. § 4100g(d).

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE