HB1204_L.004

HOUSE COMMITTEE OF REFERENCE REPORT

Chairman of Committee _____ Date _____

Committee on Business Affairs and Labor.

After consideration on the merits, the Committee recommends the following:

HB09-1204 be amended as follows:

Amend printed bill, page 3, line 15, strike "(4) (a)," and substitute "(4), (15),";

strike lines 23 through 27.

Strike page 4.

Page 5, strike lines 1 through 21 and substitute the following:

"(4) ~~**Low-dose mammography.** (a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar~~

~~year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. If an insured person who is eligible for a routine mammography screening benefit pursuant to subparagraphs (I), (II), and (III) of this paragraph (a), has not utilized such benefit during a calendar year or a contract year, then such provisions shall apply to one diagnostic screening for such year. If more than one diagnostic screening is provided for such person in a given calendar year or contract year, the other diagnostic service benefit provisions in the policy or contract shall apply with respect to such additional screenings. This mandated mammography coverage shall be provided according to the following guidelines:~~

~~(I) Provision of a single baseline mammogram for women thirty-five years of age and under forty years of age;~~

~~(II) Screening not less than once every two calendar years or contract years for women forty years of age and under fifty years of age, as specified in the insured's policy or contract, but at least once each such calendar year or contract year for a woman with risk factors to breast cancer as determined by her physician for an entity subject to part 2 or 3 of this article, or as determined by a participating physician for an entity subject to part 4 of this article;~~

~~(III) Annual screening, on a calendar year or contract year basis, for women who are fifty to sixty-five years of age.~~

~~(b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated after July 1, 1995.~~

~~(c) "Sickness and accident insurance policy" does not include~~

~~short-term, accident, fixed indemnity, specified disease policies or disability income contracts, and limited benefit or credit disability insurance, or such other insurance as defined in section 10-18-101 (3) or by the commissioner. The term does not include insurance arising out of the "Workers' Compensation Act of Colorado" or other similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.~~

~~(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this subsection (4) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.~~

(15) Notwithstanding any provision to the contrary, a small employer may purchase health benefit coverage that does not include the coverage for benefits pursuant to subsections ~~(4),~~ (5), (9), (10), (12), and (18) of this section through a basic health benefit plan pursuant to section 10-16-105 (7.2) (b) (I) or (7.2) (b) (III) or that does not include coverage for benefits pursuant to subsections (5), (9), (10), (12), ~~and (18)~~ (18) (b) (I), (18) (b) (II), AND (18) (b) (IV) THROUGH (IX) of this section through a medical evidence-based health benefit plan authorized in section 10-16-105 (7.2) (b) (IV).".

Page 6, line 12, strike "(IV)." and substitute "(IV); EXCEPT THAT THE REQUIRED COVERAGE FOR MAMMOGRAPHY SET FORTH IN SUBPARAGRAPH (III) OF PARAGRAPH (b) OF THIS SUBSECTION (18) SHALL APPLY TO A BASIC HEALTH BENEFIT PLAN ISSUED PURSUANT TO SECTION 10-16-105 (7.2) (b) (IV).";

line 13, strike "deductibles." and substitute "deductibles OR COINSURANCE.";

line 14, strike "and coinsurance" and substitute "~~and coinsurance~~";

line 19, strike "BUT SHALL NOT";

strike lines 20 and 21 and substitute the following:

"AS REQUIRED BY THE POLICY, CONTRACT, OR OTHER HEALTH CARE COVERAGE.".

Page 7, strike lines 2 through 7 and substitute the following:

"(II) CERVICAL CANCER SCREENING;

(III) (A) BREAST CANCER SCREENING WITH MAMMOGRAPHY;

(B) COVERAGE FOR BREAST CANCER SCREENING WITH MAMMOGRAPHY SHALL BE THE LESSER OF SIXTY DOLLARS PER MAMMOGRAPHY SCREENING OR THE ACTUAL CHARGE FOR SUCH SCREENING, BUT IN NO CASE SHALL THE COVERED PERSON BE REQUIRED TO PAY MORE THAN THE COPAYMENT REQUIRED BY THE POLICY OR CONTRACT FOR PREVENTIVE HEALTH CARE SERVICES. THE MINIMUM BENEFIT REQUIRED UNDER THIS SUBPARAGRAPH (III) SHALL BE ADJUSTED TO REFLECT INCREASES AND DECREASES IN THE CONSUMER PRICE INDEX.

(C) BENEFITS FOR PREVENTIVE MAMMOGRAPHY SCREENINGS SHALL BE DETERMINED ON A CALENDAR YEAR OR A CONTRACT YEAR BASIS, WHICH SHALL BE SPECIFIED IN THE POLICY OR CONTRACT. THE PREVENTIVE AND DIAGNOSTIC COVERAGES PROVIDED PURSUANT TO THIS SUBPARAGRAPH (III) SHALL IN NO WAY DIMINISH OR LIMIT DIAGNOSTIC BENEFITS OTHERWISE ALLOWABLE UNDER A POLICY. IF A COVERED PERSON WHO IS ELIGIBLE FOR A PREVENTIVE MAMMOGRAPHY SCREENING BENEFIT PURSUANT TO THIS SUBPARAGRAPH (III) HAS NOT UTILIZED SUCH BENEFIT DURING A CALENDAR YEAR OR A CONTRACT YEAR, THEN THE COVERAGE SHALL APPLY TO ONE DIAGNOSTIC SCREENING FOR THAT YEAR. IF MORE THAN ONE DIAGNOSTIC SCREENING IS PROVIDED FOR THE COVERED PERSON IN A GIVEN CALENDAR YEAR OR CONTRACT YEAR, THE OTHER DIAGNOSTIC SERVICE BENEFIT PROVISIONS IN THE POLICY OR CONTRACT SHALL APPLY WITH RESPECT TO THE ADDITIONAL SCREENINGS.".

Renumber succeeding subparagraphs accordingly.

Page 7, line 8, strike "DISORDERS ONCE EVERY" and substitute "DISORDERS;";

strike lines 9 and 10;

line 11, before "COLORECTAL", insert "(A)";

line 13, strike "polyps for ~~those~~ THE FOLLOWING" and substitute "polyps. ~~for those covered persons~~";

line 14, strike "covered persons:";

strike lines 16 and 17 and substitute the following:

"~~(I) Asymptomatic, average risk adults who are fifty years of age or older and~~";

line 18, strike "Covered" and substitute "IN ADDITION TO COVERED PERSONS ELIGIBLE FOR COLORECTAL CANCER SCREENING COVERAGE IN ACCORDANCE WITH A OR B RECOMMENDATIONS OF THE TASK FORCE, COLORECTAL CANCER SCREENING COVERAGE REQUIRED BY THIS SUBPARAGRAPH (V) SHALL ALSO BE PROVIDED TO covered".

Page 8, strike lines 3 through 6 and substitute the following:

"(VII) INFLUENZA VACCINATIONS PURSUANT TO THE SCHEDULE ESTABLISHED BY THE ACIP;

(VIII) PNEUMOCOCCAL VACCINATIONS PURSUANT TO THE SCHEDULE ESTABLISHED BY THE ACIP; AND".

Page 9, after line 18, insert the following:

"**SECTION 3.** 10-3-903 (2) (h), Colorado Revised Statutes, is amended to read:

10-3-903. Definition of transacting insurance business. (2) The provisions of this section do not apply to:

(h) Transactions in this state involving group sickness and accident or blanket sickness and accident insurance where the master policy was lawfully issued and delivered to a single employer in another state in which the company was authorized to do an insurance business, when a master policy which covers residents of this state includes mammography benefits at a level at least as comprehensive as those required by ~~section 10-16-104 (4)~~ SECTION 10-16-104 (18) (b) (III);

SECTION 4. 10-16-105 (7.2) (b) (I), (7.2) (b) (II), (7.2) (b) (III), (7.2) (b) (IV) (A), and (7.2) (b) (IV) (C), Colorado Revised Statutes, are amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee - repeal. (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers annually to determine the range of health benefit plans available. The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans. A basic health benefit plan may be based on the latest medical evidence. The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans. In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules as necessary to implement the basic and standard health benefit plans. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design described in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2):

(b) (I) A basic health benefit plan may reflect a basic health benefit plan that does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 ~~(4),~~ (5), (9), (10), (12), and (18).

(II) A basic health benefit plan may reflect a health benefit plan that is a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223. A carrier may apply deductible amounts for mandatory health benefits for mammography, prostate screening, child supervision services, or prosthetic devices pursuant to section 10-16-104 ~~(4),~~ (10), (11), ~~and (14)~~ (14), AND (18) (b) (III) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount.

(III) A basic health benefit plan may reflect a basic health benefit

plan that does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 ~~(4),~~ (5), (9), (10), (12), and (18) and is a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223. A carrier may apply deductible amounts for mandatory health benefits for child supervision services or prosthetic devices pursuant to section 10-16-104 (11) and (14) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount.

(IV) On and after January 1, 2009, a basic health benefit plan may reflect a medical evidence-based health benefit plan that:

(A) Does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (5), (9), (10), (12), and (18); EXCEPT THAT A BASIC HEALTH BENEFIT PLAN ISSUED PURSUANT TO THIS SUBPARAGRAPH (IV) SHALL INCLUDE COVERAGE FOR MAMMOGRAPHY AS SPECIFIED IN SECTION 10-16-104 (18) (b) (III);

(C) Covers limited prevention and screening based on the latest medical evidence embodied in recommendations of an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services; except that a carrier may apply deductible amounts for mandatory health benefits for mammography, child supervision services, or prosthetic devices pursuant to section 10-16-104 ~~(4),~~ (11), ~~and (14)~~ (14), AND (18) (b) (III) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount;

SECTION 5. 10-16-116 (3), Colorado Revised Statutes, is amended to read:

10-16-116. Catastrophic health insurance - coverage. (3) Insurers shall provide a written disclosure to a covered person that indicates the mandated benefits of section 10-16-104 (1), (1.7), ~~(4),~~ (5), (5.5), (8), (9), (10), (11), (12), (13), ~~and (14)~~ (14), AND (18) (b) (III) are covered benefits of the high deductible health plan offered pursuant to section 10-16-105 (7.2) (b) (II); except that the mandated benefits for mammography, prostate screenings, child health supervision services, and prosthetic devices shall be subject to policy deductibles.

SECTION 6. 10-16-129, Colorado Revised Statutes, is amended to read:

10-16-129. Health savings accounts. Any carrier authorized to conduct business in this state that offers coverage pursuant to part 2, 3, or 4 of this article may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to 26 U.S.C. sec. 223, as amended. A carrier offering a high deductible health plan that may be offered in conjunction with a health savings account may apply the deductible to mandatory health benefits for mammography, prostate cancer screening, child health supervision services, and prosthetic devices pursuant to section 10-16-104 ~~(4),~~ (10), (11), ~~and (14),~~ (14), AND (18) (b) (III) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount.".

Renumber succeeding section accordingly.

** *** ** *** **