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M E M O R A N D U M

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TO: Interested Persons

FROM: Vanessa Conway, Research Analyst, 303-866-4753

SUBJECT: Mandated Health Benefits in Colorado

Summary

This memorandum provides information on Colorado's mandated health insurance benefits. Table 1, Health Insurance Mandates in Colorado, provides a description of current state laws governing insurance benefits. The mandates are listed in the table alphabetically.

Please note that state laws apply to fully insured plans only. Plans that do not fall under the fully insured category include self-funded plans, union plans, and federal employee benefits plans. These plans are not subject to Colorado's mandated health insurance benefits laws. Mandated coverages may still be subject to deductibles, coinsurance, or other cost-sharing, or may be capped in some manner.

Table 1
Colorado Health Insurance Mandates

Insurance Benefit	Summary of Current Law
Biologically based mental illness Section 10-16-104 (5.5), C.R.S.	Every health benefit plan must provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for a physical illness, which is known as mental health parity. Every group policy, except for small group plans, must provide coverage for the treatment of biologically based mental illness and mental disorders that is no less extensive than the coverage provided for a physical illness. For example, a policy cannot cap visits to a physician for a mental illness to 20 visits unless the same cap applies to visits for a physical illness. Small group plans are exempt from this mandate. Biologically based mental illness includes schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Mental disorder means post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, general anxiety disorder, and autism spectrum disorders.
Cervical cancer vaccination Section 10-16-104 (17), C.R.S.	All individual and group insurance policies, except supplemental polices covering specific diseases or other limited benefits, must provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccine is recommended by the U.S. Department of Health and Human Services.
Complications of pregnancy and childbirth Section 10-16-104 (2), C.R.S.	Any health insurance policy covering a disability due to sickness must also cover a sickness or disease which is a complication of pregnancy or childbirth in the same way as any other similar sickness or disease is otherwise covered under the policy. Any policy providing coverage for disability due to an accident must also cover accidents that occur during the course of pregnancy or childbirth in the same way as any other similar accident is covered.
Children *Adopted children* Section 10-16-104 (6.5), C.R.S.	Whenever an entity subject to regulation under Colorado's mandated health benefit law offers coverage for dependent children, the entity must provide benefits to a child placed for adoption and adopted children under the same terms and conditions that apply to a natural dependent child, regardless of whether the adoption of the child is final.

Table 1
Colorado Health Insurance Mandates (Cont.)

Insurance Benefit	Summary of Current Law
Children (Cont.)	
Autism spectrum disorder Section 10-16-104 (1.4), C.R.S.	All health benefit plans issued or renewed in the state must provide coverage to assess, diagnose, and treat autism spectrum disorder (ASD). Treatment covered includes: • evaluation and assessment services; • behavior training and management; • habilitative or rehabilitative care, which includes speech, occupational, and physical therapies. Speech, occupation, and physical therapies may exceed 20 visits if deemed medically necessary; • pharmacy and medication if covered by the individual's health plan; • psychiatric care; • psychological care, including family counseling; and • therapeutic care, which includes speech, occupational, and applied behavioral analytic physical therapies. Any treatment for ASD must be deemed medically necessary. The law specifies that early intervention services, which are currently mandated under law, shall supplement, but not replace, ASD services.
Cleft lip and cleft palate Section 10-16-104 (1)(c)(II), C.R.S.	All group and individual insurance policies must provide coverage for a dependent child born with cleft lip or cleft palate, including oral and facial surgery, surgical management, follow-up care by a plastic and/or oral surgeon, prosthetic treatment, any medically necessary orthodontic, prosthodontic treatment, habilitative speech therapy, and audiological assessments and treatments. There is no age limit to receive benefits for coverage.
Congenital defects and birth abnormalities Section 10-16-104 (1)(c)(I), C.R.S.	All group and individual insurance policies must provide coverage for medically necessary treatment and care of medically diagnosed congenital defects and birth abnormalities for the first 31 days of the newborn's life. After the first 31 days of life, all individual and group health benefit plans must provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday. Early intervention services from the time of birth to age three are classified under “Early intervention services” below.

Table 1
Colorado Health Insurance Mandates (Cont.)

Insurance Benefit	Summary of Current Law
Children (cont.)	
Dependent children Section 10-16-104 (6), C.R.S.	An entity subject to regulation under Colorado's mandated health benefit law cannot refuse to cover a dependent child for any of the following reasons: • the child's claim was filed by a custodial parent who is not the insured under the policy; • the child does not live in the home of the parent applying for the policy; • the child does not live in the insurer's service area; • the child was born out of wedlock; or • the child is not claimed as a dependent child on the federal or state income tax returns of the child's parent.
Early intervention services Section 10-16-104 (1.3), C.R.S.	All individual and group insurance policies must provide coverage for early intervention services delivered by a qualified early intervention service provider. Services must be available from birth up to the eligible child's third birthday and are limited to a coverage amount that is adjusted annually by the commissioner). Early intervention services means services, defined by the Colorado Department of Human Services, that are authorized through an eligible child's Individual Family Service Plan.
Hearing aids for children Section 10-16-104 (19), C.R.S.	Any health benefit plan that offers hospital, surgical, or medical expense insurance, except supplemental policies that cover specific diseases or other limited benefits, must provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a licensed physician or audiologist. Coverage includes: • initial hearing aids and replacement hearing aids not more frequently than every five years; • a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and • services and supplies including the initial assessment, fitting adjustments, and auditory training.
Hospitalizations and general anesthesia for dental procedures for dependent children Section 10-16-104 (12), C.R.S.	All individual and group insurance policies, except supplemental polices that cover specific diseases or other limited benefits, must provide coverage for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other licensed facility, and for associated hospital or facility charges for dental care provided to a child when the treating dentist's opinion satisfies specific criteria defined in Colorado law, such as the child has a physical, mental, or medically compromising condition.

Table 1
Colorado Health Insurance Mandates (Cont.)

Insurance Benefit	Summary of Current Law
Children (cont.)	
Newborns Section 10-16-104 (1), C.R.S.	All group and individual insurance policies must provide coverage for a dependent newborn of the insured from the moment of birth. Unless the decision to discharge is made by an attending provider with the agreement of the mother, coverage for a newborn hospital stay following a normal vaginal delivery must not be limited to less than 48 hours; following a cesarean delivery hospital stay coverage must not be limited to less than 96 hours.
Phenylketonuria (PKU) Section 10-16-104 (1)(c)(III), C.R.S.	All group and individual insurance policies must provide coverage for a dependent child born with an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, fatty acids, and severe protein allergic conditions including the following diagnoses: phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, hisidinemia, urea cycle disorder, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, and propionic acidemia. Coverage must include medical foods for home use prescribed by a physician.
Clinical trials and studies Section 10-16-104 (20), C.R.S.	All individual and group health benefit plans are required to provide coverage for routine patient care costs while the covered person participates in a clinical trial or study as long as the coverage is a benefit that the covered person would receive if he or she were receiving standard chronic disease treatment outside of the clinical trial or study. The clinical trials must meet specific requirements as to review board approvals and patient care.
Contraception Section 10-16-104 (3)(a)(I), C.R.S.	All individual and group health insurance policies must provide coverage for contraception in the same manner as any other sickness, disease, or condition that is otherwise covered by that policy.
Dependent health coverage for persons under 26 years of age Section 10-16-104.3, C.R.S.	All individual and group health benefit plans that offer dependent coverage must offer the same dependent coverage for a child who is under 26 years of age. Carriers may not deny or restrict coverage for a child under the age of 26 based on the child's eligibility for other coverage or the following factors: • residency with the policyholder or another person; • presence or absence of financial dependence on the policyholder or another person; • marital or civil union status; or • employment status.

Table 1
Colorado Health Insurance Mandates (Cont.)

Insurance Benefit	Summary of Current Law
Diabetes Section 10-16-104 (13), C.R.S.	Any health benefit plan, except supplemental policies covering a specified disease or other limited benefits, that provides hospital, surgical, or medical expense insurance must provide coverage for diabetes that includes equipment, supplies, and outpatient self-management training and education, including nutritional therapy if prescribed.
Hospice care availability Section 10-16-104 (8), C.R.S.	No individual or group policy that provides hospital, surgical, or major medical coverage on an expense-incurred basis may be sold in Colorado unless the policyholder has the opportunity to purchase coverage for benefits for the costs of home health services and hospice care.
Maternity coverage Section 10-16-104 (1)(b), C.R.S. Section 10-16-104 (3), C.R.S.	All individual and group health insurance policies must cover normal pregnancy and childbirth in the same manner as any other condition, sickness, injury, or disease that is otherwise covered. Coverage for a hospital stay following a normal vaginal birth must be for at least 48 hours. Coverage for a hospital stay following a cesarean section must be for at least 96 hours. Individual health policies may exclude coverage on the grounds that pregnancy was a preexisting condition, but the exclusion may not apply to subsequent pregnancies.
Off-label use of cancer drugs Section 10-16-104.6, C.R.S.	A health benefit plan that provides coverage for prescription drugs may not limit or exclude coverage for any drug approved by the federal Food and Drug Administration for the use in treatment for cancer on the basis that the drug has not been approved for the specific type of cancer being treated.
Oral anticancer medication Section 10-16-104 (21), C.R.S.	Any health benefit plan that provides coverage for cancer chemotherapy treatment must cover orally administered anticancer medication at a cost not to exceed the coinsurance percentage or relative copayment amount that is applied to intravenously administered or injected anticancer medication. Oral medication is covered if it is approved by the federal Food and Drug Administration, determined to be medically necessary to kill or slow the growth of cancerous cells, and not prescribed primarily for the convenience of the patient or physician.
Prescription eye drop refill Section 10-16-104 (22), C.R.S.	Any health benefit plan, except supplemental policies covering a specified disease or other limited benefits, that provides coverage for prescription eye drops must provide coverage for an additional bottle, if requested at the time the original prescription is filled, and the prescription states that an additional bottle is needed for use in a day care center, school, or adult day program, limited to one every three months. A plan also must provide coverage for a renewal of the original prescription if the prescription states that additional quantities are needed and the renewal does not exceed the number of additional quantities needed, and is requested a number of days after receipt of the original prescription or latest renewal, as follows: • 21 days for a 30-day supply; • 42 days for a 60-day supply; or • 63 days for a 90-day supply.

Table 1
Colorado Health Insurance Mandates (Cont.)

Insurance Benefit	Summary of Current Law
Preventative health care services Section 10-16-104 (18), C.R.S.	All individual and group insurance policies must provide coverage for preventative health care services. Preventative care services are determined according to recommendations by the U.S. Preventative Services Task Force. Preventative services include: • alcohol misuse screening and behavioral counseling interventions; • annual influenza vaccination; • breast cancer screening with mammography, including an annual screening for all individuals with at least one risk factor including a family history of breast cancer, being 40 years of age or older, or a genetic predisposition to breast cancer; • cervical cancer screening; • child health supervision services and childhood immunizations; • cholesterol screening; • colorectal cancer screening; • pneumococcal vaccination; • tobacco use screening and cessation programs; and • any other preventive services included in the U.S. Preventative Services Task Force A or B Recommendations. Coverage for preventative care is not subject to a policy deductible or coinsurance.
Prostate cancer screening Section 10-16-104 (10), C.R.S.	All individual and group health insurance policies must cover annual screenings for men over the age of 50 years and men over 40 years of age who are in high-risk categories. The coverage is limited to $65 per screening or the actual cost of the screening, whichever is less. The screening must be performed by a qualified medical professional and include at a minimum a prostate-specific antigen (PSA) blood test and a digital rectal exam.
Prosthetic devices Section 10-16-104 (14), C.R.S.	Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, must provide coverage for benefits for prosthetic devices that equal the benefits provided for under federal laws for health insurance for the aged and disabled. Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.
Reproductive health and gynecological care Section 10-16-139 (1), C.R.S.	Health benefit plans that provide coverage for reproductive health or gynecological care must allow women covered by the plan direct access to a participating obstetrician, gynecologist, physician assistant, or a certified nurse midwife.

Source: Legislative Council Staff.