Colorado
Legislative
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MEMORANDUM

December 15, 2009

TO: Interested Persons

FROM: Kelly Stapleton, Senior Research Assistant, 303-866-4789

SUBJECT: Mandated Health Insurance Benefits

This memorandum provides information on Colorado's mandated health insurance benefits. The following table, "Health Insurance Mandates in Colorado" provides a description of current state laws governing insurance benefits, and the effective date for each law. It is important to keep in mind 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 laws. Mandates are listed in the table alphabetically.

Colorado Health Insurance Mandates

Updated December 2009

Insurance Benefit	Summary of Current Law	Effective Date
Availability of treatment for alcoholism Section 10-16-104 (9), C.R.S.	No hospitalization or medical benefits contract on a group basis may be issued without an opportunity to purchase coverage for the benefits for the treatment of, and conditions arising from, alcoholism. Annual policy benefits must include: • inpatient treatment up to 45 days; and • outpatient benefits up to $500 that may be furnished by a licensed hospital, a public or private facility providing services for the treatment of alcohol, or a mental health facility.	January 1, 1976
Biologically-based mental illness Section 10-16-104 (5.5), C.R.S.	Every group policy, plan certificate, and contract of a carrier must provide coverage for the treatment of biologically-based mental illness and treatment of mental disorders that is no less extensive than the coverage provided for a physical illness. For example, a policy cannot cap an individual visiting 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, and general anxiety disorder. The term also includes anorexia nervosa, and bulimia nervosa to the extent that the disorders are treated on an out-patient, day treatment, and in-patient basis, excluding residential treatment.	January 1, 1998 January 1, 2007 — mental health parity and anorexia nervosa/bulmia provision added.
Cervical cancer vaccination Section 10-16-104 (17), C.R.S.	All individual and group insurance polices, 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.	January 1, 2008
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 which occur during the course of pregnancy or childbirth in the same way as any other similar accident is covered.	January 1, 1976

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Insurance Benefit	Summary of Current Law	Effective Date
Children *Immunizations* Section 10-16-104 (1.5), C.R.S.	All individual and group health insurance polices that provided coverage for pediatric vaccinations on May 1, 1993, cannot reduce the level of coverage in effect on that date.	July 1, 1994 Repealed January 1, 2010 Provision to be covered under preventative health services Section 10-16-104 (18), C.R.S.
Preventative services including immunizations Section 10-16-104 (11), C.R.S.	Preventative services and immunizations must be provided under basic and standard health benefit plans. In addition, an individual, small group, or large group health benefit plan that provides coverage for a family member of the insured must provide coverage to such family member's children up to the age of 13.	May 22, 1995
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 dependant children 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 dependant child on the federal or state income tax returns of the child's parent.	June 5, 1991
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 dependant 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.	July 1, 1994
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.	September 1, 1998

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Children (*continued*)		
Newborns Section 10-16-104 (1), C.R.S.	All group and individual insurance policies must provide coverage for a dependant newborn of the insured from the moment of birth.	July 1, 1975
Cleft lip and cleft palate Section 10-16-104 (1)(c)(II), C.R.S.	All group and individual insurance polices must provide coverage for a dependant 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, any medically necessary orthodontic, prosthodontic treatment, habilitative speech therapy, and audiological assessments and treatments. There is no age limit to receive benefits for coverage.	July 1, 1975
Congenital defects and birth abnormalities Section 10-16-104(1)(c)(I), C.R.S. Section 10-16-104 (1.7), C.R.S.	All group and individual insurance polices 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.	July 1, 1975 (Up to 31 days coverage for newborn) January 1, 2000 (treatment and care) January 1, 2008 (treatment and care ages 3 to 5)
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 and services must be available from birth up to the child's third birthday and are limited to $5,725 of coverage. 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.	January 1, 2008
Phenylketonuria (PKU) Section 10-16-104 (1)(c)(III), C.R.S.	All group and individual insurance polices must provide coverage for a dependant child born with an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, and fatty acids 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.	January 1, 2002

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Insurance Benefit	Summary of Current Law	Effective Date
Children continued *Autism spectrum disorder* Section 10-16-104 (1.4), C.R.S.	All health insurance policies which are subject to state regulation, excluding individual health benefit plans, are required to provide coverage to assess, diagnose, and treat autism spectrum disorder (ASD). Treatment covered includes: • evaluation and assessment services; • behavior training and management; • psychiatric care; • psychological care, including family counseling; • therapeutic care, which includes applied behavioral analysis; • habilitative or rehabilitative care, which includes speech, occupational, and physical therapies. Speech, occupation, and physical therapies may exceed 20 visits if deemed medically necessary; and • pharmacy and medication if covered by the individual's health plan. Any treatment for ASD must be deemed medically necessary. The annual maximum benefit for applied behavior analysis is $34,000 for children from birth to 8 years of age, and $12,000 for individuals from age 9 to 19 years old. The law specifies that early intervention services, which are currently mandated under law, are not to supplant services provided under the law, but are to act as a wrap around service, or in addition to the services provided under the law.	July 1, 2010
Hearing aids for children 10-16-104(19), C.R.S.	Any health benefit plan that offers hospital, surgical, or medical expense insurance, 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 5 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 intimal assessment, fitting adjustments, and auditory training.	January 1, 2009

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Clinical trials and studies 10-16-104 (20), C.R.S.	All individual and group health benefits 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.	August 5, 2010
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.	July 1, 1998
Hospice care availablity Section 10-16-104 (8), C.R.S.	No individual or group policy which provides hospital, surgical, or major medical coverage on an expense incurred basis can 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.	July 1, 1985
Low-dose mammography Section 10-16-104 (4), C.R.S.	All individual and group health insurance policies, except supplemental policies covering a specified disease or other limited benefits, must cover mammograms for adult women as follows: a single baseline mammogram for women ages 35 to 39; at least biennial screening for women ages 40 to 49, but no less than annually for women at high risk; and annual screening for women ages 50 to 65.	January 1, 1990 Provision repealed January 1, 2010 Provision to be covered under preventative health services Section 10-16-104 (18), C.R.S.
Maternity coverage Section 10-16-104 (3), C.R.S.	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.	January 1, 1976

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Mental illness Section 10-16-104 (5), C.R.S.	Every group policy or contract providing hospitalization or medical benefits must provide benefits for conditions arising from mental illness. In the case of a basic coverage benefits plan, coverage must include up to 45 days inpatient care, or 90 days for partial hospitalization in any one 12-month period. In the case of a major medical benefits plan, coverage must cover outpatient services furnished by a comprehensive health care service corporation, hospital, or a community mental health center or other mental health clinic approved by the Department of Human Services.	August 1, 1976
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; • cervical cancer screening; • cholesterol screening; • breast cancer screening with mammography; • colorectal cancer screening; • childhood immunizations; • annual influenza vaccination; • pneumococcal vaccination; and • tobacco use screening and cessation programs. Coverage for preventative care is not subject to a policy deductible or coinsurance.	January 1, 2010
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 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.	June 9, 1993

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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 those 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.	January 1, 2001
Reproductive health and gynecological care Section 10-16-107 (5), C.R.S.	Managed care plans that cover reproductive health or gynecological care must either: (1) allow enrolled women direct access to a participating obstetrician, gynecologist, or a certified nurse midwife; or (2) have procedures in place to ensure that, if an enrolled woman requests a referral to a participating obstetrician, gynecologist, or a certified nurse midwife, the referral is not unreasonably withheld.	January 31, 1997