A BILL FOR AN ACT

CONCERNING HEALTH CARE COVERAGE FOR REPRODUCTIVE HEALTH CARE.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

Section 2 of the bill requires all individual and group health benefit plans issued, amended, or renewed on or after January 1, 2020, to provide coverage for specified reproductive health care services, drugs, devices, products, and procedures. Carriers are prohibited from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for the coverage required under the bill and from imposing restrictions or
delays on the coverage. Under specified circumstances, section 2 permits a carrier to offer a religious employer a plan that does not include coverage for abortion procedures that are contrary to the religious employer's religious tenets. Section 2 also prohibits a carrier from excluding an individual from participation in, denying an individual benefits under, or otherwise discriminating against an individual in the administration of a plan on the basis of the individual's actual or perceived race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.

Section 4 directs the department of health care policy and financing to administer a program to reimburse the cost of specified reproductive health care services, drugs, devices, products, and procedures provided to eligible individuals, which is defined to include individuals with reproductive health care needs who are enrolled in the medicaid program or the children's basic health plan or who are otherwise disqualified for participation in the medicaid program based on their immigration status.

The program must also provide medicaid or children's basic health plan benefits, as applicable, to pregnant individuals for 180 days, rather than the mandated 60 days, post-pregnancy, regardless of whether the individual's medicaid or children's basic health plan eligibility would otherwise terminate during that period based on an increase in income.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds that:

(a) Every individual possesses fundamental rights to privacy, dignity, and autonomy to make personal reproductive decisions, including the decision to seek reproductive health care such as prenatal care, contraception, and abortion;

(b) Comprehensive reproductive health care, including safe abortion, is a vital component of an individual's overall health, and access to abortion is also a core component to individuals' social and economic equality. Indeed, the United States Supreme Court has firmly and repeatedly held, and specifically stated in Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), that the due
process clause of the fourteenth amendment to the United States constitution protects a person's right to "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" and recognized that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives".

(c) Before, during, and after pregnancy, adequate and affordable access to quality health care and high-quality providers helps ensure healthy births, healthy babies, and healthy parents. However, women who lack adequate prenatal care are three to four times more likely to die of pregnancy-related complications. In Colorado, maternal mortality rates have been rising, nearly doubling between 2008 and 2013.

(d) Moreover, nearly half of pregnancies in the United States are unintended; individuals who lack insurance coverage or access to subsidized services are more likely to have unintended pregnancies and childbearing; and unintended childbearing is associated with negative consequences such as delayed prenatal care, increased risk of physical violence during pregnancy, maternal depression, decreased likelihood of breastfeeding, low birth weight, decreased mental and physical health during childhood, and lower educational attainment for the child;

(e) To raise healthy families and contribute to a strong community, individuals also need affordable access to the full range of reproductive health care services, including screenings for cancer and sexually transmitted infections (STIs), contraceptive services, abortion care, prenatal care, labor and delivery services, and breastfeeding support and services. In Colorado, STI rates continue to be a serious health concern: For four of the most common STIs, Colorado has a higher
incidence rate than more than fifteen other states.

(f) The right to make private, individual health care decisions can be meaningless if reproductive health care is unaffordable. Insurance coverage for and otherwise affordable access to preventive reproductive health care services, including full pregnancy coverage, are critical to comprehensive health care and to allowing individuals and families to thrive. Therefore, it is necessary to ensure that every person in this state, regardless of income or immigration status, has access to the full range of reproductive health care services, drugs, devices, products, and procedures without the barrier of cost-sharing. In the long run, providing comprehensive reproductive health care for all Coloradans will help ensure the economic security, health, and well-being of Colorado residents.

SECTION 2. In Colorado Revised Statutes, 10-16-104, amend as it will become effective January 1, 2019, (3)(a)(I)(A); and add (3.5) as follows:

10-16-104. Mandatory coverage provisions - definitions - rules. (3) Maternity coverage. (a) (I) (A) All group sickness and accident insurance policies providing coverage within the state and issued to an employer by an entity subject to part 2 of this article 16, all group health service contracts issued by an entity subject to part 3 or 4 of this article 16 and issued to an employer, all individual sickness and accident insurance policies issued by an entity subject to part 2 of this article 16, and all individual health care or indemnity contracts issued by an entity subject to part 3 or 4 of this article 16, except supplemental policies covering a specified disease or other limited benefit, must insure against the expense of normal pregnancy and childbirth or provide coverage for

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maternity care and provide coverage for contraception in the same manner as any other sickness, injury, disease, or condition is otherwise covered under the policy or contract; except that coverage for contraception must be consistent with the requirements in section 10-16-104.2 and subsection (3.5) of this section.

(3.5) **Reproductive health care.** (a) All individual and group health benefit plans that are issued, amended, or renewed in the state on or after January 1, 2020, except supplemental policies covering a specified disease or other limited benefit, must provide coverage for all of the following services, drugs, devices, products, and procedures:

(I) Women's preventive health services identified by the health resources and services administration in the United States department of health and human services or the Women's Preventive Services Initiative as of January 1, 2017, in the following areas:

(A) Breast cancer screening for average-risk women;

(B) Breastfeeding services and supplies;

(C) Screening for cervical cancer;

(D) Contraception, subject to subsection (3.5)(b) of this section;

(E) Screening for gestational diabetes mellitus;

(F) Screening for HIV infection;

(G) Screening for interpersonal and domestic violence;

(H) Counseling for sexually transmitted infection; and

(I) Well woman preventive visits;

(II) Screening to determine whether counseling and
TESTING RELATED TO THE BRCA1 OR BRCA2 GENETIC MUTATIONS IS
INDICATED AND TESTING AND GENETIC COUNSELING RELATED TO THE
BRCA1 OR BRCA2 GENETIC MUTATIONS IF INDICATED;

(III) ABORTION, TO THE EXTENT PERMITTED BY THE COLORADO
CONSTITUTION; AND

(IV) VOLUNTARY STERILIZATION AND SERVICES RELATED TO
STERILIZATION, INCLUDING MANAGEMENT OF SIDE EFFECTS.

(b) FOR PURPOSES OF THE COVERAGE REQUIRED BY THIS
SUBSECTION (3.5) FOR CONTRACEPTION, A HEALTH BENEFIT PLAN SUBJECT
TO THIS SUBSECTION (3.5) MUST PROVIDE COVERAGE FOR:

(I) ANY CONTRACEPTIVE DRUG, DEVICE, OR PRODUCT APPROVED
BY THE FDA, SUBJECT TO ALL OF THE FOLLOWING:

(A) IF THERE IS A THERAPEUTIC EQUIVALENT OF A CONTRACEPTIVE
DRUG, DEVICE, OR PRODUCT APPROVED BY THE FDA, THE HEALTH BENEFIT
PLAN MAY PROVIDE COVERAGE FOR EITHER THE REQUESTED
CONTRACEPTIVE DRUG, DEVICE, OR PRODUCT OR ONE OR MORE
THERAPEUTIC EQUIVALENTS OF THE REQUESTED DRUG, DEVICE, OR
PRODUCT;

(B) IF A CONTRACEPTIVE DRUG, DEVICE, OR PRODUCT COVERED BY
THE HEALTH BENEFIT PLAN IS DEEMED MEDICALLY INADVISABLE BY THE
COVERED PERSON'S PROVIDER, THE HEALTH BENEFIT PLAN MUST COVER AN
ALTERNATIVE CONTRACEPTIVE DRUG, DEVICE, OR PRODUCT PRESCRIBED
BY THE PROVIDER;

(C) A HEALTH BENEFIT PLAN MUST PROVIDE COVERAGE WITHOUT
A PRESCRIPTION FOR ALL CONTRACEPTIVE DRUGS THAT ARE AVAILABLE
FOR OVER-THE-COUNTER SALE AND ARE APPROVED BY THE FDA; AND

(D) A HEALTH BENEFIT PLAN MAY NOT INFRINGE UPON A COVERED
PERSON'S CHOICE OF CONTRACEPTIVE DRUG, DEVICE, OR PRODUCT AND MAY NOT REQUIRE PRIOR AUTHORIZATION, STEP THERAPY, OR OTHER UTILIZATION CONTROL TECHNIQUES FOR MEDICALLY APPROPRIATE COVERED CONTRACEPTIVE DRUGS, DEVICES, OR OTHER PRODUCTS APPROVED BY THE FDA;

(II) SERVICES RELATED TO THE ADMINISTRATION AND MONITORING OF CONTRACEPTIVE DRUGS, DEVICES, AND PRODUCTS, INCLUDING MANAGEMENT OF SIDE EFFECTS;

(III) COUNSELING FOR CONTINUED ADHERENCE TO A PRESCRIBED REGIMEN;

(IV) DEVICE INSERTION AND REMOVAL; AND

(V) THE PROVISION OF ALTERNATIVE CONTRACEPTIVE DRUGS, DEVICES, OR PRODUCTS DEEMED MEDICALLY APPROPRIATE IN THE JUDGMENT OF THE COVERED PERSON'S PROVIDER.

(c) A CARRIER SHALL NOT IMPOSE ANY DEDUCTIBLE, COINSURANCE, COPAYMENT, OR OTHER COST-SHARING REQUIREMENT ON A COVERED PERSON FOR THE COVERAGE REQUIRED BY THIS SUBSECTION (3.5), EXCEPT TO THE EXTENT THAT COVERAGE WITHOUT COST-SHARING WOULD DISQUALIFY A HIGH-DEDUCTIBLE HEALTH BENEFIT PLAN FROM ELIGIBILITY FOR A HEALTH SAVINGS ACCOUNT PURSUANT TO 26 U.S.C. SEC. 223. A CARRIER SHALL REIMBURSE A PROVIDER FOR PROVIDING THE SERVICES DESCRIBED IN THIS SUBSECTION (3.5) WITHOUT ANY DEDUCTION FOR COINSURANCE, COPAYMENTS, OR ANY OTHER COST-SHARING AMOUNTS.

(d) EXCEPT AS AUTHORIZED UNDER THIS SUBSECTION (3.5), A CARRIER SHALL NOT IMPOSE ANY RESTRICTIONS OR DELAYS ON THE COVERAGE REQUIRED BY THIS SUBSECTION (3.5). IF AN OUT-OF-NETWORK
PROVIDER PROVIDES SERVICES, DRUGS, DEVICES, PRODUCTS, OR PROCEDURES REQUIRED BY THIS SUBSECTION (3.5), THE CARRIER SHALL COVER THE SERVICES, DRUGS, DEVICES, PRODUCTS, OR PROCEDURES WITHOUT IMPOSING ANY COST-SHARING REQUIREMENT ON THE COVERED PERSON IF:

(I) THERE IS NO IN-NETWORK PROVIDER TO FURNISH THE SERVICE, DRUG, DEVICE, PRODUCT, OR PROCEDURE THAT IS GEOGRAPHICALLY ACCESSIBLE OR ACCESSIBLE IN A REASONABLE AMOUNT OF TIME, AS DEFINED BY THE COMMISSIONER BY RULE; OR

(II) AN IN-NETWORK PROVIDER IS UNABLE OR UNWILLING TO PROVIDE THE SERVICE IN A TIMELY MANNER.

(e) THIS SUBSECTION (3.5) DOES NOT REQUIRE A CARRIER TO COVER:

(I) EXPERIMENTAL OR INVESTIGATIONAL TREATMENTS;

(II) CLINICAL TRIALS OR DEMONSTRATION PROJECTS, EXCEPT TO THE EXTENT REQUIRED UNDER SUBSECTION (20) OF THIS SECTION;

(III) TREATMENTS THAT DO NOT CONFORM TO ACCEPTABLE AND CUSTOMARY STANDARDS OF MEDICAL PRACTICE; OR

(IV) TREATMENTS FOR WHICH THERE ARE INSUFFICIENT DATA TO DETERMINE EFFICACY.

(f) (I) A CARRIER MAY OFFER TO A RELIGIOUS EMPLOYER A HEALTH BENEFIT PLAN THAT DOES NOT INCLUDE COVERAGE FOR ABORTION PROCEDURES THAT ARE CONTRARY TO THE RELIGIOUS EMPLOYER'S RELIGIOUS TENETS ONLY IF THE CARRIER NOTIFIES IN WRITING ALL EMPLOYEES WHO ARE ELIGIBLE TO BE ENROLLED IN THE RELIGIOUS EMPLOYER'S HEALTH BENEFIT PLAN OF THE PROCEDURES THE EMPLOYER REFUSES TO COVER FOR RELIGIOUS REASONS.
(II) For purposes of this subsection (3.5)(f), a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity;

(B) The entity primarily employs persons who share the religious tenets of the entity;

(C) The entity serves primarily persons who share the religious tenets of the entity; and

(D) The entity is a nonprofit organization as described in section 6033 (a)(3)(A)(i) or 6033 (a)(3)(A)(iii) of the Federal "Internal Revenue Code of 1986", as amended.

(g) If the commissioner concludes that enforcement of this subsection (3.5) may adversely affect the allocation of federal funds to this state, the commissioner may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(h) A carrier that is subject to this subsection (3.5) shall make readily accessible to covered persons and potential covered persons, in a consumer-friendly format, information about the coverage described in this subsection (3.5). The carrier must provide the information on its website and in writing upon request by a covered person or potential covered person.

(i) (I) A carrier shall not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability:

(A) Exclude an individual from participation in, deny an individual benefits under, or otherwise subject an individual to
DISCRIMINATION IN THE ADMINISTRATION OF THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN SUBJECT TO THIS SUBSECTION (3.5); OR

(B) DISCRIMINATE IN THE COVERAGE OF OR PAYMENT FOR THE SERVICES, DRUGS, DEVICES, PRODUCTS, AND PROCEDURES DESCRIBED IN THIS SUBSECTION (3.5).

(II) A CARRIER WHO VIOLATES THIS SUBSECTION (3.5)(i) COMMITS A DISCRIMINATORY AND UNLAWFUL PRACTICE UNDER SECTION 24-34-6 AND IS SUBJECT TO PENALTIES, CIVIL LIABILITY, AND OTHER RELIEF SPECIFIED IN PART 6 OF ARTICLE 34 OF TITLE 24.

SECTION 3. In Colorado Revised Statutes, 10-16-102, add (27.5) as follows:

10-16-102. Definitions. As used in this article 16, unless the context otherwise requires:

(27.5) "FDA" MEANS THE FEDERAL FOOD AND DRUG ADMINISTRATION.

SECTION 4. In Colorado Revised Statutes, add 25.5-5-324 as follows:

25.5-5-324. Reproductive health care program - required reimbursements - limited or no federal financial participation - definitions - rules - data collection. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "CHILDREN'S BASIC HEALTH PLAN" MEANS THE HEALTH PLAN CREATED PURSUANT TO ARTICLE 8 OF THIS TITLE 25.5.

(b) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WITH REPRODUCTIVE HEALTH CARE NEEDS WHO:

(I) IS ELIGIBLE FOR AND ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM;
(II) WOULD BE ELIGIBLE TO ENROLL IN THE MEDICAL ASSISTANCE
PROGRAM BUT FOR 8 U.S.C. SECS. 1611 AND 1612 AND SECTION
25.5-5-101 (2)(b); OR

(III) IS ELIGIBLE FOR AND ENROLLED IN THE CHILDREN'S BASIC
HEALTH PLAN.

(c) "FDA" MEANS THE FEDERAL FOOD AND DRUG
ADMINISTRATION.

(d) "MEDICAL ASSISTANCE PROGRAM" MEANS THE PROGRAM
ESTABLISHED IN THIS ARTICLE 5 AND ARTICLES 4 AND 6 OF THIS TITLE 25.5.

(e) "REPRODUCTIVE HEALTH CARE PROGRAM" MEANS THE
PROGRAM ESTABLISHED IN THIS SECTION.

(2) THE STATE DEPARTMENT SHALL ADMINISTER A REPRODUCTIVE
HEALTH CARE PROGRAM TO REIMBURSE THE COST OF THE FOLLOWING
MEDICALLY NECESSARY REPRODUCTIVE HEALTH CARE SERVICES, DRUGS,
DEVICES, PRODUCTS, AND PROCEDURES FOR ELIGIBLE INDIVIDUALS:

(a) WOMEN'S PREVENTIVE HEALTH SERVICES IDENTIFIED BY THE
HEALTH RESOURCES AND SERVICES ADMINISTRATION IN THE UNITED
STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES OR THE WOMEN'S
PREVENTIVE SERVICES INITIATIVE AS OF JANUARY 1, 2017, IN THE
FOLLOWING AREAS:

(I) BREAST CANCER SCREENING FOR AVERAGE-RISK WOMEN;

(II) BREASTFEEDING SERVICES AND SUPPLIES;

(III) SCREENING FOR CERVICAL CANCER;

(IV) CONTRACEPTION, SUBJECT TO SUBSECTION (3) OF THIS
SECTION;

(V) SCREENING FOR GESTATIONAL DIABETES MELLITUS;

(VI) SCREENING FOR HIV INFECTION;
(VII) Screening for interpersonal and domestic violence;
(VIII) Counseling for sexually transmitted infection; and
(IX) Well woman preventive visits;

(b) Screening to determine whether counseling and testing related to the BRCA1 or BRCA2 genetic mutations is indicated and testing and genetic counseling related to the BRCA1 or BRCA2 genetic mutations if indicated;

(c) Abortion, to the extent permitted by the Colorado Constitution; and

(d) Voluntary sterilization and services related to sterilization, including management of side effects.

(3) For purposes of the benefits required by subsection (2)(a)(IV) of this section for contraception, the reproductive health care program must reimburse the cost of:

(a) Any contraceptive drug, device, or product approved by the FDA, subject to all of the following:

   (I) If there is a therapeutic equivalent of a contraceptive drug, device, or product approved by the FDA, the reproductive health care program may reimburse the cost of either the requested contraceptive drug, device, or product or one or more therapeutic equivalents of the requested drug, device, or product;

   (II) If a contraceptive drug, device, or product is deemed medically inadvisable by the eligible individual's provider, the reproductive health care program must reimburse the cost for an alternative contraceptive drug, device, or product prescribed by the provider;
(III) The reproductive health care program must provide the reimbursement without a prescription for all contraceptive drugs that are available for over-the-counter sale and are approved by the FDA; and

(IV) The reproductive health care program may not infringe upon an eligible individual’s choice of contraceptive drug, device, or product and may not require prior authorization, step therapy, or other utilization control techniques for medically necessary covered contraceptive drugs, devices, or other products approved by the FDA;

(b) Services related to the administration and monitoring of contraceptive drugs, devices, and products, including management of side effects;

c) Counseling for continued adherence to a prescribed regimen;

d) Device insertion and removal; and

e) The provision of alternative contraceptive drugs, devices, or products deemed medically necessary in the judgment of the eligible individual’s provider.

(4) For a pregnant individual who is determined eligible under section 25.5-5-101 or 25.5-8-109, notwithstanding sections 25.5-5-101 (1)(c) and 25.5-8-109 (5)(a)(I), benefits under the medical assistance program or the children’s basic health plan, as applicable, continue for the one hundred eighty days following the pregnancy, even if the individual’s eligibility would otherwise terminate during that period due to an increase in income.
(5) The state department shall collect data and analyze the cost-effectiveness of the services, drugs, devices, products, and procedures reimbursed by the reproductive health care program pursuant to this section.

(6) The state board shall adopt rules as necessary to implement this section, including rules specifying the manner by which eligible individuals are able to enroll in the reproductive health care program.

(7) The state department shall reimburse the cost of medically necessary reproductive health care services, drugs, devices, products, and procedures for eligible individuals regardless of whether an eligible individual or a benefit required by this section receives federal financial participation under the medical assistance program or children's basic health plan.

SECTION 5. Act subject to petition - effective date - applicability. (1) This act takes effect January 1, 2020; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be held in November 2018 and, in such case, will take effect on January 1, 2020.

(2) Section 2 of this act applies to health benefit plans issued, amended, or renewed on or after the applicable effective date of this act.