CHAPTER 344

INSURANCE

HOUSE BILL 09-1204

BY REPRESENTATIVE(S) Massey, McGihon, Acree, Casso, Fischer, Frangas, Green, Kefalas, Kerr A., Merrifield, Middleton, Primavera, Priola, Ryden, Scanlan, Curry, Kerr J., Todd;
also SENATOR(S) Boyd, Foster, Gibbs, Newell, Schwartz, Shaffer B., Tochtrop.

AN ACT

CONCERNING HEALTH INSURANCE COVERAGE FOR PREVENTIVE HEALTH CARE SERVICES, AND, IN CONNECTION THEREWITH, EXPANDING REQUIRED COVERAGE FOR CERTAIN PREVENTIVE HEALTH CARE SERVICES THAT RECEIVE HIGH RECOMMENDATIONS FROM THE UNITED STATES PREVENTIVE SERVICES TASK FORCE AND THE NATIONAL COMMISSION ON PREVENTION PRIORITIES.

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

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

(a) There are numerous barriers that limit the delivery of effective clinical preventive services to insured Coloradans, including the financial barriers insured Coloradans face because of cost-sharing mechanisms such as deductibles and copayment or coinsurance requirements that are often imposed in health insurance policies;

(b) These cost-sharing mechanisms can cause patients to delay or forego even the most cost-effective preventive services and risk death or disease that might have been avoided or at least detected at an early stage had the patient obtained preventive services;

(c) While reducing cost-sharing for all preventive services would have the undesired effect of increasing insurance premiums, which would likewise increase the number of uninsured individuals in the state, targeting cost-sharing limitations to those preventive services that are the most cost-effective will have a significant impact on disease and death among Coloradans; and

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Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(d) It is therefore important to limit the ability of health insurance carriers to impose cost-sharing mechanisms for, and thereby encourage Coloradans to obtain, specific preventive health care services that have been recognized by the United States preventive services task force and the national commission on prevention priorities as significantly cost-effective and having a substantial impact on the prevention of morbidity and mortality in Coloradans.

SECTION 2. 10-16-104 (1.5), (4), (15), and (18), Colorado Revised Statutes, are amended to read:

10-16-104. Mandatory coverage provisions - definitions. (1.5) ~~**Child immunization coverage.** An entity subject to the provisions of this article, article 8 of this title, or section 607 (1) of the federal "Employment Retirement Income Security Act of 1974", as amended, that provided coverage for pediatric vaccinations on May 1, 1993, shall not reduce the level of the coverage in effect on that date.~~

(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).

(18) **Preventive health care services.** (a) (I) Except as specified in subparagraph (II) of this paragraph (a), the following policies and contracts that are delivered, issued, renewed, or reinstated on or after ~~July 1, 2009~~ JANUARY 1, 2010, shall provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18):

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to ~~the provisions of~~ part 2 of this article;

(B) 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; and

(C) Any other individual or group health care coverage offered to residents of this state.

(II) Nothing in this subsection (18) shall be deemed to apply to a basic health benefit plan issued pursuant to section 10-16-105 (7.2) (b) (I), (7.2) (b) (III), or (7.2) (b) (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).

(III) Coverage shall not be subject to policy deductibles OR COINSURANCE. Copayments ~~and coinsurance~~ may apply ~~For a health maintenance organization that directly provides health care services to its enrollees, the policy deductibles, copayments, coinsurance, and any other form of cost sharing for the total costs associated with the coverage required by this subsection (18) shall not exceed ten percent of the cost of the preventive health care service required by this subsection (18)~~ AS REQUIRED BY THE POLICY, CONTRACT, OR OTHER HEALTH CARE COVERAGE.

(b) The coverage required by this subsection (18) shall include PREVENTIVE HEALTH CARE SERVICES FOR THE FOLLOWING, IN ACCORDANCE WITH THE A OR B RECOMMENDATIONS OF THE TASK FORCE FOR THE PARTICULAR PREVENTIVE HEALTH CARE SERVICE:

(I) ALCOHOL MISUSE SCREENING AND BEHAVIORAL COUNSELING INTERVENTIONS FOR ADULTS BY PRIMARY CARE PROVIDERS;

(II) CERVICAL CANCER SCREENING;

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

(B) COVERAGE FOR BREAST CANCER SCREENING WITH MAMMOGRAPHY SHALL BE THE LESSER OF ONE HUNDRED 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.

(IV) CHOLESTEROL SCREENING FOR LIPID DISORDERS;

(V) (A) COLORECTAL CANCER SCREENING coverage for ~~the~~ tests ~~specified in subparagraph (II) of this paragraph (b)~~ for the early detection of colorectal cancer and adenomatous polyps. ~~for those covered persons who are specified in subparagraph (I) of this paragraph (b):~~

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

(B) 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 persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider;

~~(II) The following tests as determined by the provider that detect adenomatous polyps or colorectal cancer. Modalities that are currently included in an A recommendation or a B recommendation by the task force.~~

(VI) CHILDHOOD IMMUNIZATIONS PURSUANT TO THE SCHEDULE ESTABLISHED BY THE ACIP;

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

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

(IX) TOBACCO USE SCREENING OF ADULTS AND TOBACCO CESSATION INTERVENTIONS BY PRIMARY CARE PROVIDERS.

(c) For purposes of this subsection (18):

(I) "ACIP" MEANS THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION IN THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR ANY SUCCESSOR ENTITY.

~~(I)~~ (II) "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service ~~for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:~~

~~(A) Found good evidence that the preventive health care service improves~~

~~important health outcomes; and~~

~~(B) Concluded that the benefits of the preventive health care service substantially outweigh its harms~~ BECAUSE THE TASK FORCE FOUND THERE IS A HIGH CERTAINTY THAT THE NET BENEFIT OF THE PREVENTIVE HEALTH CARE SERVICE IS SUBSTANTIAL.

~~(II)~~ (III) "B recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service ~~for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:~~

~~(A) Found at least fair evidence that the preventive health care service improves important health outcomes; and~~

~~(B) Concluded that the benefits of the preventive health care service outweigh its harms~~ BECAUSE THE TASK FORCE FOUND THERE IS A HIGH CERTAINTY THAT THE NET BENEFIT IS MODERATE OR THERE IS MODERATE CERTAINTY THAT THE NET BENEFIT IS MODERATE TO SUBSTANTIAL.

~~(III)~~ (IV) "Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.

(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 provided pursuant to this subsection (18) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

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.

SECTION 7. Act subject to petition - effective date - applicability. (1) This act shall take effect January 1, 2010.

(2) However, if a referendum petition is filed against this act or an item, section, or part of this act during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution, then the act, item, section, or part, shall not take effect unless approved by the people at a biennial regular general election and shall take effect on the date specified in subsection (1) or on the date of the official declaration of the vote thereon by proclamation of the governor, whichever is later.

(3) The provisions of this act shall apply to policies or contracts issued, delivered, renewed, or reinstated on or after the applicable effective date of this act.

Approved: June 1, 2009