First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 25-0094.01 Kristen Forrestal x4217 **HOUSE BILL 25-1002**

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A BILL FOR AN ACT

CONCERNING THE DETERMINATION OF HEALTH BENEFITS COVERAGE FOR MENTAL HEALTH SERVICES.

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.)

The bill clarifies that the health benefits coverage for the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders must be no less extensive than the coverage provided for any physical illness. The bill requires that every health benefit plan must provide coverage for:

- The placement, including admission, continued stay,

transfer, and discharge of a covered person and determinations relating to mental health disorders in accordance with criteria developed by the American Academy of Child and Adolescent Psychiatry or the American Association for Community Psychiatry; and

- Medically necessary treatment of covered behavioral, mental health, and substance use disorder benefits, consistent with specified criteria.

The bill also specifies criteria to be used for utilization review, service intensity, the level of care for covered persons, and provider reimbursement.

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

SECTION 1. In Colorado Revised Statutes, 10-16-104, **amend** (5.5)(a)(I), (5.5)(a)(V)(A), (5.5)(a)(V)(B), (5.5)(a)(V)(D), (5.5)(b), and (5.5)(d); and **add** (5.5)(a)(I.5), (5.5)(a)(V)(F), (5.5)(a)(VI), (5.5)(c.3), and (5.5)(c.5) as follows:

10-16-104. Mandatory coverage provisions - definitions - rules - applicability. (5.5) **Behavioral, mental health, and substance use disorders - utilization review criteria - federal treatment limitation requirements - meaningful benefits - rules - definitions.** (a) (I) Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), must provide coverage:

(A) For the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders that is no less extensive than the coverage provided for any physical illness, ~~and~~ that complies with the requirements of the MHPAEA, and THAT DOES NOT DISCRIMINATE IN ITS BENEFIT DESIGN AGAINST INDIVIDUALS BECAUSE OF THEIR PRESENT OR PREDICTED BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER;

(B) At a minimum, for the treatment of substance use disorders in

accordance with the American Society of Addiction Medicine criteria for placement, INCLUDING ADMISSION, CONTINUED STAY, TRANSFER, AND DISCHARGE OF A COVERED PERSON; medical necessity; and utilization management determinations as set forth in the most recent edition of "The ASAM Criteria: TREATMENT CRITERIA for Addictive, Substance-related, and Co-occurring Conditions"; except that the commissioner may identify by rule, in consultation with the department of health care policy and financing and the behavioral health administration in the department of human services, ~~an~~ alternate nationally recognized and evidence-based substance-use-disorder-specific NOT-FOR-PROFIT UTILIZATION REVIEW criteria THAT IS CONSISTENT WITH GENERALLY ACCEPTED STANDARDS OF SUBSTANCE USE DISORDER CARE for placement, medical necessity, or utilization ~~management~~ REVIEW, if the American Society of Addiction Medicine criteria are no longer available or relevant or do not follow best practices for substance use disorder treatment;

(C) AT A MINIMUM, FOR PLACEMENT, INCLUDING ADMISSION, CONTINUED STAY, TRANSFER, AND DISCHARGE OF A COVERED PERSON, DETERMINATIONS RELATING TO MENTAL HEALTH DISORDERS IN ACCORDANCE WITH THE AGE-APPROPRIATE LEVEL-OF-CARE OR SERVICE INTENSITY CRITERIA DEVELOPED BY THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY OR THE AMERICAN ASSOCIATION FOR COMMUNITY PSYCHIATRY AS SET FORTH IN THE MOST RECENT EDITION OF THE "LEVEL OF CARE UTILIZATION SYSTEM", THE "CHILD AND ADOLESCENT LEVEL OF CARE / SERVICE INTENSITY UTILIZATION SYSTEM", AND THE "EARLY CHILDHOOD SERVICE INTENSITY INSTRUMENT"; EXCEPT THAT THE COMMISSIONER MAY IDENTIFY BY RULE, IN CONSULTATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND

FINANCING AND THE BEHAVIORAL HEALTH ADMINISTRATION IN THE DEPARTMENT OF HUMAN SERVICES, ALTERNATE, AGE-APPROPRIATE NATIONALLY RECOGNIZED AND EVIDENCE-BASED NOT-FOR-PROFIT MENTAL-HEALTH-DISORDER-SPECIFIC UTILIZATION REVIEW CRITERIA THAT ARE CONSISTENT WITH GENERALLY ACCEPTED STANDARDS OF MENTAL HEALTH DISORDER CARE FOR PATIENT PLACEMENT, TRANSFER, OR DISCHARGE DETERMINATIONS, IF THE CRITERIA IN THIS SUBSECTION (5.5)(a)(I)(C) ARE NO LONGER AVAILABLE OR RELEVANT OR DO NOT FOLLOW BEST PRACTICES FOR MENTAL HEALTH DISORDER TREATMENT; AND

(D) FOR MEDICALLY NECESSARY TREATMENT OF COVERED BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFITS, INCLUDING SERVICES THAT ARE CONSISTENT WITH CRITERIA, GUIDELINES, OR CONSENSUS RECOMMENDATIONS FROM NATIONALLY RECOGNIZED NOT-FOR-PROFIT CLINICAL SPECIALTY ASSOCIATIONS OF THE RELEVANT BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER SPECIALTY.

(I.5) (A) ALL UTILIZATION REVIEW AND UTILIZATION REVIEW CRITERIA MUST BE CONSISTENT WITH CURRENT GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE.

(B) WHEN A HEALTH-CARE PROVIDER HAS COMPLETED AN ASSESSMENT CONCERNING SERVICE INTENSITY OR LEVEL-OF-CARE PLACEMENT, CONTINUED STAY, OR TRANSFER OR DISCHARGE USING THE RELEVANT CRITERIA IN SUBSECTION (5.5)(a)(I)(B) OR (5.5)(a)(I)(C) OF THIS SECTION, THE HEALTH BENEFIT PLAN MUST AUTHORIZE PLACEMENT AT THE SERVICE INTENSITY AND LEVEL OF CARE CONSISTENT WITH THAT CRITERIA AND MUST NOT APPLY DIFFERENT, ADDITIONAL, CONFLICTING, OR

MORE RESTRICTIVE CRITERIA. IF THE ASSESSED LEVEL OF PLACEMENT IS NOT AVAILABLE, THE HEALTH BENEFIT PLAN MUST AUTHORIZE THE NEXT HIGHER LEVEL OF CARE; IF THERE IS A DISAGREEMENT WITH THE ACCURACY OF THE PROVIDER'S ASSESSMENT, AS PART OF THE ADVERSE BENEFIT DETERMINATION, THE HEALTH BENEFIT PLAN MUST PROVIDE FULL DETAIL OF ITS ASSESSMENT AND THE RELEVANT CRITERIA USED IN THE ASSESSMENT TO THE PROVIDER AND THE COVERED PERSON.

(C) A HEALTH BENEFIT PLAN MUST NOT LIMIT BENEFITS OR COVERAGE FOR CHRONIC BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDERS TO SHORT-TERM SYMPTOM REDUCTION AT ANY LEVEL-OF-CARE PLACEMENT.

(V) A carrier offering a health benefit plan subject to the requirements of this subsection (5.5) shall:

(A) Comply with the nonquantitative treatment limitation requirements specified in ~~45 CFR 146.136 (c)(4)~~ 45 CFR 146.136 OR 29 CFR 2590.712, or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which, in addition to the limitations and examples listed in 45 CFR 146.136 (c)(4)(ii) and ~~(c)(4)(iii)~~ (c)(4)(vi) OR 29 CFR 2590.712 (c)(4)(ii) AND (c)(4)(vi), or any successor regulation, and ~~78 FR 68246~~ 78 FED. REG. 68246 (NOVEMBER 13, 2013) AND 89 FED. REG. 77586 (SEPTEMBER 23, 2024), include the methods by which the carrier establishes and maintains its provider networks pursuant to section 10-16-704 and responds to deficiencies in the ability of its networks to provide timely access to care;

(B) Comply with the financial requirements and quantitative treatment limitations specified in 45 CFR 146.136 (c)(2) and (c)(3) or any

successor regulation OR 29 CFR 2590.712 (c)(2) AND (c)(3);

(D) Establish procedures to authorize MEDICALLY NECESSARY treatment with ~~a~~ AN APPROPRIATE nonparticipating provider AND TO PROVIDE CASE MANAGEMENT SERVICES TO A COVERED PERSON TO ASSIST THE PERSON IN FINDING AN APPROPRIATE NONPARTICIPATING PROVIDER, if a covered service is not available within established time and distance standards, and within a reasonable period, after a service is requested, and with the same coinsurance, deductible, or copayment requirements, ACCRUING TO IN-NETWORK ANNUAL COST-SHARING LIMITS, as would apply if the services were provided by a participating provider, and at no greater cost to the covered person than if the services were obtained at or from a participating provider; ~~and~~

(F) NOT REVERSE OR ALTER A DETERMINATION OF MEDICAL NECESSITY MADE PURSUANT TO THIS SUBSECTION (5.5), INCLUDING DOWNGRADING OR BUNDLING THE CODING OF A CLAIM, THROUGH A REVIEW OR AUDIT OF A CLAIM, EXCEPT IN CASES OF FRAUD OR WHERE THE COVERED PERSON DID NOT HAVE A VALID POLICY WHEN THE SERVICE WAS PROVIDED.

(VI) IF A HEALTH BENEFIT PLAN PROVIDES ANY BENEFITS FOR A MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER IN ANY CLASSIFICATION OF BENEFITS, IT MUST PROVIDE MEANINGFUL BENEFITS FOR THAT MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER IN EVERY CLASSIFICATION IN WHICH MEDICAL OR SURGICAL BENEFITS ARE PROVIDED. WHETHER THE BENEFITS PROVIDED ARE MEANINGFUL BENEFITS IS DETERMINED IN COMPARISON TO THE BENEFITS PROVIDED FOR MEDICAL CONDITIONS AND SURGICAL PROCEDURES IN THE CLASSIFICATION AND REQUIRES, AT A MINIMUM, COVERAGE OF BENEFITS FOR THAT CONDITION

OR DISORDER IN EACH CLASSIFICATION IN WHICH THE HEALTH BENEFIT PLAN PROVIDES BENEFITS FOR ONE OR MORE MEDICAL CONDITIONS OR SURGICAL PROCEDURES. A HEALTH BENEFIT PLAN DOES NOT PROVIDE MEANINGFUL BENEFITS UNLESS IT PROVIDES BENEFITS FOR A CORE TREATMENT FOR THAT CONDITION OR DISORDER IN EACH CLASSIFICATION IN WHICH THE HEALTH BENEFIT PLAN PROVIDES BENEFITS FOR A CORE TREATMENT FOR ONE OR MORE MEDICAL CONDITIONS OR SURGICAL PROCEDURES. A CORE TREATMENT FOR A CONDITION OR DISORDER IS A STANDARD TREATMENT OR COURSE OF TREATMENT, THERAPY, SERVICE, OR INTERVENTION INDICATED BY GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE. IF THERE IS NO CORE TREATMENT FOR A COVERED MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER WITH RESPECT TO A CLASSIFICATION, THE HEALTH BENEFIT PLAN IS NOT REQUIRED TO PROVIDE BENEFITS FOR A CORE TREATMENT FOR SUCH CONDITION OR DISORDER IN THAT CLASSIFICATION, BUT MUST PROVIDE BENEFITS FOR SUCH CONDITION OR DISORDER IN EVERY CLASSIFICATION IN WHICH MEDICAL OR SURGICAL BENEFITS ARE PROVIDED.

(b) The commissioner:

(I) May adopt rules as necessary to ensure that this subsection (5.5) is implemented and administered in compliance with federal law; ~~and~~

(II) Shall adopt rules to establish reasonable time periods for visits with a provider for treatment of a behavioral, mental health, or substance use disorder after an initial visit with a provider; AND

(III) MAY ADOPT RULES AS NECESSARY TO SPECIFY DATA TESTING REQUIREMENTS TO DETERMINE PLAN DESIGN AND IN-OPERATION PARITY

COMPLIANCE FOR NONQUANTITATIVE TREATMENT LIMITATIONS, INCLUDING PRIOR AUTHORIZATION, CONCURRENT REVIEW, RETROSPECTIVE REVIEW, CREDENTIALING STANDARDS, AND REIMBURSEMENT RATES.

(c.3) THIS SUBSECTION (5.5) APPLIES TO ANY INDIVIDUAL, ENTITY, OR CONTRACTING PROVIDER THAT PERFORMS UTILIZATION REVIEW FUNCTIONS ON BEHALF OF A HEALTH BENEFIT PLAN.

(c.5) A CARRIER OFFERING A HEALTH BENEFIT PLAN SHALL NOT ADOPT, IMPOSE, OR ENFORCE TERMS IN ITS POLICIES OR PROVIDER AGREEMENT, IN WRITING OR IN OPERATION, THAT UNDERMINE, ALTER, OR CONFLICT WITH THE REQUIREMENTS OF THIS SUBSECTION (5.5).

(d) As used in this subsection (5.5):

(I) "APPROPRIATE NONPARTICIPATING PROVIDER" MEANS A PROVIDER WHO IS ACCESSIBLE AND HAS THE TRAINING AND EXPERIENCE NECESSARY TO PROVIDE AGE-APPROPRIATE, MEDICALLY NECESSARY TREATMENT OF A BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER.

(II) "Behavioral, mental health, and substance use disorder":

~~(I)~~ (A) Means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of

~~(A)~~ the "International Statistical Classification of Diseases and Related Health Problems",

~~(B)~~ the "Diagnostic and Statistical Manual of Mental Disorders", or

~~(C)~~ the "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood"; and

~~(II)~~ (B) Includes autism spectrum disorders, as defined in subsection (1.4)(a)(III) of this section.

(III) "GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE" MEANS STANDARDS OF CARE AND CLINICAL PRACTICE THAT ARE GENERALLY RECOGNIZED BY HEALTH-CARE PROVIDERS PRACTICING IN RELEVANT CLINICAL SPECIALTIES SUCH AS PSYCHIATRY, PSYCHOLOGY, CLINICAL SOCIOLOGY, ADDICTION MEDICINE AND COUNSELING, AND BEHAVIORAL HEALTH TREATMENT. VALID, EVIDENCE-BASED SOURCES REFLECTING GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE INCLUDE PEER-REVIEWED SCIENTIFIC STUDIES AND MEDICAL LITERATURE; CLINICAL PRACTICE GUIDELINES AND RECOMMENDATIONS OF NONPROFIT HEALTH-CARE PROVIDER PROFESSIONAL ASSOCIATIONS, SPECIALTY SOCIETIES, AND FEDERAL GOVERNMENT AGENCIES; AND DRUG LABELING APPROVED BY THE FDA.

(IV) "MEDICALLY NECESSARY TREATMENT" MEANS A SERVICE OR PRODUCT ADDRESSING THE SPECIFIC NEEDS OF A PATIENT FOR THE PURPOSE OF SCREENING, PREVENTING, DIAGNOSING, MANAGING, OR TREATING A BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER OR ITS SYMPTOMS, INCLUDING MINIMIZING THE PROGRESSION OF THE DISORDER, IN A MANNER THAT IS:

(A) IN ACCORDANCE WITH THE GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE;

(B) CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY, EXTENT, SITE, AND DURATION; AND

(C) NOT PRIMARILY FOR THE ECONOMIC BENEFIT OF THE INSURER OR PURCHASER OR FOR THE CONVENIENCE OF THE COVERED PERSON,

TREATING PHYSICIAN, OR OTHER HEALTH-CARE PROVIDER.

(V) "UTILIZATION REVIEW" MEANS PROSPECTIVELY, RETROSPECTIVELY, OR CONCURRENTLY REVIEWING AND APPROVING, MODIFYING, DELAYING, OR DENYING REQUESTS BY HEALTH-CARE PROVIDERS, COVERED PERSONS, OR THEIR AUTHORIZED REPRESENTATIVES FOR COVERAGE, BASED IN WHOLE OR IN PART ON MEDICAL NECESSITY, OR FOR OUT-OF-NETWORK SERVICES REQUIRED PURSUANT TO SUBSECTION (5.5)(a)(V)(D) OF THIS SECTION.

(VI) "UTILIZATION REVIEW CRITERIA" MEANS ANY CRITERIA, STANDARDS, PROTOCOLS, OR GUIDELINES USED BY A HEALTH BENEFIT PLAN TO CONDUCT UTILIZATION REVIEW.

SECTION 2. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly; 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 such period, 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 2026 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.