

**First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO**

ENGROSSED

*This Version Includes All Amendments Adopted
on Second Reading in the House of Introduction*

LLS NO. 25-0094.01 Kristen Forrestal x4217

HOUSE BILL 25-1002

HOUSE SPONSORSHIP

Brown and Gilchrist, Johnson, McCormick, Winter T.

SENATE SPONSORSHIP

Amabile and Pelton B., Simpson

House Committees
Health & Human Services

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING THE DETERMINATION OF HEALTH BENEFITS COVERAGE**
102 **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,

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing law.
Dashes through the words or numbers indicate deletions from existing law.

HOUSE
Amended 2nd Reading
February 7, 2025

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.

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

2 **SECTION 1.** In Colorado Revised Statutes, 10-16-104, **amend**
3 (5.5)(a)(I), (5.5)(a)(V)(A), (5.5)(a)(V)(B), (5.5)(a)(V)(D), (5.5)(b) and
4 (5.5)(d); and **add** (5.5)(a)(I.5), (5.5)(a)(V)(F), (5.5)(a)(VI), (5.5)(c.3),
5 (5.5)(c.5), and (5.5)(e) as follows:

6 **10-16-104. Mandatory coverage provisions - definitions - rules**
7 **- applicability. (5.5) Behavioral, mental health, and substance use**
8 **disorders - utilization review criteria - federal treatment limitation**
9 **requirements - meaningful benefits - rules - definitions. (a) (I) Every**
10 health benefit plan subject to part 2, 3, or 4 of this article 16, except those
11 described in section 10-16-102 (32)(b), must provide coverage:

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

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

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

15 [REDACTED]
16 (C) FOR MEDICALLY NECESSARY TREATMENT OF COVERED
17 BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFITS,
18 INCLUDING SERVICES THAT ARE CONSISTENT WITH CRITERIA, GUIDELINES,
19 OR CONSENSUS RECOMMENDATIONS FROM NATIONALLY RECOGNIZED
20 NOT-FOR-PROFIT CLINICAL SPECIALTY ASSOCIATIONS OF THE RELEVANT
21 BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER SPECIALTY.

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

26 [REDACTED]
27 (B) IN CONDUCTING UTILIZATION REVIEW OF COVERED SERVICES

1 FOR THE DIAGNOSIS, PREVENTION, AND TREATMENT OF BEHAVIORAL OR
2 MENTAL HEALTH DISORDERS, A HEALTH BENEFIT PLAN SHALL APPLY THE
3 CRITERIA AND GUIDELINES SET FORTH IN THE MOST RECENT VERSION OF
4 THE TREATMENT CRITERIA DEVELOPED BY UNAFFILIATED NATIONALLY
5 RECOGNIZED NOT-FOR-PROFIT CLINICAL SPECIALTY ASSOCIATIONS OF THE
6 RELEVANT BEHAVIORAL OR MENTAL HEALTH DISORDERS. IN CONDUCTING
7 UTILIZATION REVIEW OF COVERED SERVICES FOR THE DIAGNOSIS,
8 PREVENTION, AND TREATMENT OF SUBSTANCE USE DISORDERS, A HEALTH
9 BENEFIT PLAN SHALL APPLY THE CRITERIA SPECIFIED IN SUBSECTION
10 (5.5)(a)(I)(B) OF THIS SECTION.

11 (C) IN CONDUCTING UTILIZATION REVIEW RELATING TO SERVICE
12 INTENSITY, LEVEL OF CARE PLACEMENT, OR ANY OTHER PATIENT CARE
13 DECISIONS THAT ARE WITHIN THE SCOPE OF THE SOURCES SPECIFIED IN
14 SUBSECTIONS (5.5)(a)(I)(B) AND (5.5)(a)(I.5)(B) OF THIS SECTION, A
15 HEALTH BENEFIT PLAN SHALL NOT APPLY DIFFERENT, ADDITIONAL,
16 CONFLICTING, OR MORE RESTRICTIVE UTILIZATION REVIEW CRITERIA THAN
17 THE CRITERIA SET FORTH IN THOSE SOURCES. FOR ALL SERVICE INTENSITY
18 AND LEVEL OF CARE PLACEMENT DECISIONS, THE HEALTH BENEFIT PLAN
19 MUST AUTHORIZE PLACEMENT AT THE SERVICE INTENSITY AND LEVEL OF
20 CARE CONSISTENT WITH THE ASSESSMENT OF THE COVERED PERSON USING
21 THE RELEVANT PATIENT PLACEMENT CRITERIA SPECIFIED IN SUBSECTIONS
22 (5.5)(a)(I)(B) AND (5.5)(a)(I.5)(B) OF THIS SECTION. IF THERE IS A
23 DISAGREEMENT, AS PART OF THE ADVERSE BENEFIT DETERMINATION, THE
24 HEALTH BENEFIT PLAN MUST PROVIDE FULL DETAIL OF ITS ASSESSMENT
25 AND THE RELEVANT CRITERIA USED IN THE ASSESSMENT TO THE PROVIDER
26 AND THE COVERED PERSON.

27 (D) IN CONDUCTING UTILIZATION REVIEW THAT IS OUTSIDE THE

1 SCOPE OF THE CRITERIA SPECIFIED IN SUBSECTIONS (5.5)(a)(I)(B) AND
2 (5.5)(a)(I.5)(B) OF THIS SECTION OR RELATED TO ADVANCEMENTS IN
3 TECHNOLOGY OR TYPES OF LEVELS OF CARE THAT ARE NOT ADDRESSED IN
4 THE MOST RECENT VERSIONS OF THE SOURCES SPECIFIED IN THOSE
5 SUBSECTIONS, A HEALTH BENEFIT PLAN SHALL CONDUCT UTILIZATION
6 REVIEW IN ACCORDANCE WITH SUBSECTION (5.5)(a)(I.5)(A) OF THIS
7 SECTION. IF A HEALTH BENEFIT PLAN PURCHASES OR LICENSES UTILIZATION
8 REVIEW CRITERIA PURSUANT TO THIS SUBSECTION (5.5)(a)(I.5)(D), THE
9 HEALTH BENEFIT PLAN SHALL VERIFY AND DOCUMENT BEFORE USE THAT
10 THE CRITERIA COMPLY WITH THE REQUIREMENTS OF SUBSECTION
11 (5.5)(a)(I.5)(A) OF THIS SECTION.

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

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

18 (A) Comply with the nonquantitative treatment limitation
19 requirements specified in ~~45 CFR 146.136 (c)(4)~~ 45 CFR 146.136 OR 29
20 CFR 2590.712, or any successor regulation, regarding any limitations that
21 are not expressed numerically but otherwise limit the scope or duration
22 of benefits for treatment, which, in addition to the limitations and
23 examples listed in 45 CFR 146.136 (c)(4)(ii) and ~~(c)(4)(iii)~~ (c)(4)(vi) OR
24 29 CFR 2590.712 (c)(4)(ii) AND (c)(4)(vi), or any successor regulation,
25 and ~~78 FR 68246~~ 78 FED. REG. 68246 (NOVEMBER 13, 2013) AND 89 FED.
26 REG. 77586 (SEPTEMBER 23, 2024), include the methods by which the
27 carrier establishes and maintains its provider networks pursuant to section

1 10-16-704 and responds to deficiencies in the ability of its networks to
2 provide timely access to care;

3 (B) Comply with the financial requirements and quantitative
4 treatment limitations specified in 45 CFR 146.136 (c)(2) and (c)(3) or any
5 successor regulation OR 29 CFR 2590.712 (c)(2) AND (c)(3);

6 (D) Establish procedures to authorize MEDICALLY NECESSARY
7 treatment with ~~a~~ AN APPROPRIATE nonparticipating provider AND TO
8 PROVIDE SERVICES TO MAKE AVAILABLE THE COVERED SERVICE if a
9 covered service is not available within established time and distance
10 standards, and within a reasonable period, after a service is requested, and
11 with the same coinsurance, deductible, or copayment requirements,
12 ACCRUING TO IN-NETWORK ANNUAL COST-SHARING LIMITS, as would
13 apply if the services were provided by a participating provider, and at no
14 greater cost to the covered person than if the services were obtained at or
15 from a participating provider; ~~and~~

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

22 (VI) IF A HEALTH BENEFIT PLAN PROVIDES ANY BENEFITS FOR A
23 MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER IN ANY
24 CLASSIFICATION OF BENEFITS, IT MUST PROVIDE MEANINGFUL BENEFITS
25 FOR THAT MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER IN
26 EVERY CLASSIFICATION IN WHICH MEDICAL OR SURGICAL BENEFITS ARE
27 PROVIDED. WHETHER THE BENEFITS PROVIDED ARE MEANINGFUL BENEFITS

1 IS DETERMINED IN COMPARISON TO THE BENEFITS PROVIDED FOR MEDICAL
2 CONDITIONS AND SURGICAL PROCEDURES IN THE CLASSIFICATION AND
3 REQUIRES, AT A MINIMUM, COVERAGE OF BENEFITS FOR THAT CONDITION
4 OR DISORDER IN EACH CLASSIFICATION IN WHICH THE HEALTH BENEFIT
5 PLAN PROVIDES BENEFITS FOR ONE OR MORE MEDICAL CONDITIONS OR
6 SURGICAL PROCEDURES. A HEALTH BENEFIT PLAN DOES NOT PROVIDE
7 MEANINGFUL BENEFITS UNLESS IT PROVIDES BENEFITS FOR A CORE
8 TREATMENT FOR THAT CONDITION OR DISORDER IN EACH CLASSIFICATION
9 IN WHICH THE HEALTH BENEFIT PLAN PROVIDES BENEFITS FOR A CORE
10 TREATMENT FOR ONE OR MORE MEDICAL CONDITIONS OR SURGICAL
11 PROCEDURES. A CORE TREATMENT FOR A CONDITION OR DISORDER IS A
12 STANDARD TREATMENT OR COURSE OF TREATMENT, THERAPY, SERVICE,
13 OR INTERVENTION INDICATED BY GENERALLY ACCEPTED STANDARDS OF
14 BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE. IF
15 THERE IS NO CORE TREATMENT FOR A COVERED MENTAL HEALTH
16 CONDITION OR SUBSTANCE USE DISORDER WITH RESPECT TO A
17 CLASSIFICATION, THE HEALTH BENEFIT PLAN IS NOT REQUIRED TO PROVIDE
18 BENEFITS FOR A CORE TREATMENT FOR SUCH CONDITION OR DISORDER IN
19 THAT CLASSIFICATION, BUT MUST PROVIDE BENEFITS FOR SUCH CONDITION
20 OR DISORDER IN EVERY CLASSIFICATION IN WHICH MEDICAL OR SURGICAL
21 BENEFITS ARE PROVIDED.

22 (b) The commissioner:

23 (I) May adopt rules as necessary to ensure that this subsection
24 (5.5) is implemented and COMPLIANTLY administered; in compliance with
25 federal law and shall adopt rules to establish reasonable time periods for
26 visits with a provider for treatment of a behavioral, mental health, or
27 substance use disorder after an initial visit with a provider.

1 (II) MAY ADOPT RULES TO ESTABLISH CARRIER UTILIZATION
2 REVIEW COMPLIANCE IN ACCORDANCE WITH SUBSECTIONS (5.5)(a)(I.5)(B)
3 AND (5.5)(a)(I.5)(C) OF THIS SECTION;

4 (III) MAY ADOPT RULES AS NECESSARY TO SPECIFY DATA TESTING
5 REQUIREMENTS TO DETERMINE PLAN DESIGN AND APPLICATION OF PARITY
6 COMPLIANCE FOR NONQUANTITATIVE TREATMENT LIMITATIONS USING
7 OUTCOMES DATA;

8 (IV) MAY ADOPT RULES TO SET STANDARD DEFINITIONS FOR
9 COVERAGE REQUIREMENTS, INCLUDING PROCESSES, STRATEGIES,
10 EVIDENTIARY STANDARDS, AND OTHER FACTORS;

11 (V) MAY ADOPT RULES TO ESTABLISH SPECIFIC TIMELINES FOR
12 CARRIER COMPLIANCE TO PROVIDE COMPARATIVE ANALYSIS INFORMATION
13 TO THE DIVISION FOR REVIEW, INCLUDING THE EFFECT OF A CARRIER'S
14 LACK OF SUFFICIENT COMPARATIVE ANALYSES TO DEMONSTRATE
15 COMPLIANCE; AND

16 (V) MAY ADOPT RULES TO ESTABLISH REASONABLE TIME PERIODS
17 AND DOCUMENTATION OF SUCH TIME PERIODS FOR VISITS WITH A
18 PROVIDER FOR TREATMENT OF A BEHAVIORAL, MENTAL HEALTH, OR
19 SUBSTANCE USE DISORDER AFTER AN INITIAL VISIT WITH A PROVIDER.

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

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

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

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

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

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

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

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

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

17 (H) (B) Includes autism spectrum disorders, as defined in
18 subsection (1.4)(a)(III) of this section.

19 (III) "GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL,
20 MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE" MEANS
21 STANDARDS OF CARE AND CLINICAL PRACTICE THAT ARE GENERALLY
22 RECOGNIZED BY HEALTH-CARE PROVIDERS PRACTICING IN RELEVANT
23 CLINICAL SPECIALTIES SUCH AS PSYCHIATRY, PSYCHOLOGY, CLINICAL
24 SOCIAL WORK, PSYCHIATRIC NURSING, ADDICTION MEDICINE AND
25 COUNSELING, AND BEHAVIORAL HEALTH TREATMENT. VALID,
26 EVIDENCE-BASED SOURCES REFLECTING GENERALLY ACCEPTED
27 STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE

1 DISORDER CARE INCLUDE PEER-REVIEWED SCIENTIFIC STUDIES AND
2 MEDICAL LITERATURE; CLINICAL PRACTICE GUIDELINES AND
3 RECOMMENDATIONS OF NONPROFIT HEALTH-CARE PROVIDER
4 PROFESSIONAL ASSOCIATIONS, SPECIALTY SOCIETIES, AND FEDERAL
5 GOVERNMENT AGENCIES; AND DRUG LABELING APPROVED BY THE FDA.

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

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

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

16 (C) NOT PRIMARILY FOR THE ECONOMIC BENEFIT OF THE INSURER
17 OR PURCHASER OR FOR THE CONVENIENCE OF THE COVERED PERSON,
18 TREATING PHYSICIAN, OR OTHER HEALTH-CARE PROVIDER.

19 (V) "UTILIZATION REVIEW" MEANS PROSPECTIVELY,
20 RETROSPECTIVELY, OR CONCURRENTLY REVIEWING AND APPROVING,
21 MODIFYING, DELAYING, OR DENYING REQUESTS BY HEALTH-CARE
22 PROVIDERS, COVERED PERSONS, OR THEIR AUTHORIZED REPRESENTATIVES
23 FOR COVERAGE, BASED IN WHOLE OR IN PART ON MEDICAL NECESSITY, OR
24 FOR OUT-OF-NETWORK SERVICES REQUIRED PURSUANT TO SUBSECTION
25 (5.5)(a)(V)(D) OF THIS SECTION.

26 (VI) "UTILIZATION REVIEW CRITERIA" MEANS AN EVALUATION OF
27 THE NECESSITY, APPROPRIATENESS, AND EFFICIENCY OF THE USE OF

1 HEALTH-CARE SERVICES, PROCEDURES, AND FACILITIES, INCLUDING
2 OUT-OF-NETWORK SERVICES REQUIRED PURSUANT TO SUBSECTION
3 (5.5)(a)(V)(D) OF THIS SECTION. "UTILIZATION REVIEW CRITERIA" DOES
4 NOT INCLUDE AN INDEPENDENT MEDICAL EXAMINATION PROVIDED FOR IN
5 ANY POLICY.

6 (e) (I) SUBSECTION (5.5)(d) OF THIS SECTION DOES NOT EXPAND
7 COVERAGE REQUIREMENTS BEYOND THE STATE ESSENTIAL HEALTH
8 BENEFITS BENCHMARK PLAN AS REQUIRED PURSUANT TO 45 CFR 156.111.

9 (II) IF AN EXCLUSION FOR BEHAVIORAL HEALTH, MENTAL HEALTH,
10 OR SUBSTANCE USE DISORDER SERVICES IS NOT PERMITTED UNDER THE
11 MHPAEA, COVERAGE FOR THESE SERVICES MUST MEET THE
12 REQUIREMENTS OF SUBSECTION (5.5)(d) OF THIS SECTION.

13 **SECTION 2. Act subject to petition - effective date.** This act
14 takes effect January 1, 2026; except that, if a referendum petition is filed
15 pursuant to section 1 (3) of article V of the state constitution against this
16 act or an item, section, or part of this act within the ninety-day period
17 after final adjournment of the general assembly, then the act, item,
18 section, or part will not take effect unless approved by the people at the
19 general election to be held in November 2026 and, in such case, will take
20 effect on the date of the official declaration of the vote thereon by the
21 governor.