First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

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

HOUSE SPONSORSHIP

Brown and Gilchrist, Johnson, McCormick, Winter T., Bacon, Bird, Clifford, Duran, English, Froelich, Garcia, Hamrick, Jackson, Joseph, Lieder, Lindsay, Mabrey, Marshall, McCluskie, Paschal, Rutinel, Rydin, Smith, Stewart K., Stewart R., Story, Taggart, Titone, Valdez, Woodrow

SENATE SPONSORSHIP

Amabile and Pelton B., Simpson

House Committees
Health & Human Services

Senate Committees
Health & Human Services

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,

HOUSE
3rd Reading Unamended
February 10, 2025

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

accordance with the American Society of Addiction Medicine criteria for placement, 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; AND

(C) 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) 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. IF THE REQUESTED SERVICE
18 INTENSITY OR LEVEL OF CARE PLACEMENT IS INCONSISTENT WITH THE
19 HEALTH BENEFIT PLAN'S ASSESSMENT USING THE RELEVANT CRITERIA, AS
20 PART OF ANY ADVERSE BENEFIT DETERMINATION, THE HEALTH BENEFIT
21 PLAN SHALL PROVIDE FULL DETAIL OF ITS ASSESSMENT AND THE RELEVANT
22 CRITERIA USED IN THE ASSESSMENT TO THE PROVIDER AND THE COVERED
23 PERSON.
24 (D) IN CONDUCTING UTILIZATION REVIEW THAT IS OUTSIDE THE
25 SCOPE OF THE CRITERIA SPECIFIED IN SUBSECTIONS (5.5)(a)(I)(B) AND
26 (5.5)(a)(I.5)(B) OF THIS SECTION OR RELATED TO ADVANCEMENTS IN
27 TECHNOLOGY OR TYPES OF LEVELS OF CARE THAT ARE NOT ADDRESSED IN

THE MOST RECENT VERSIONS OF THE SOURCES SPECIFIED IN THOSE SUBSECTIONS, A HEALTH BENEFIT PLAN SHALL CONDUCT UTILIZATION REVIEW IN ACCORDANCE WITH SUBSECTION (5.5)(a)(I.5)(A) OF THIS SECTION. IF A HEALTH BENEFIT PLAN PURCHASES OR LICENSES UTILIZATION REVIEW CRITERIA PURSUANT TO THIS SUBSECTION (5.5)(a)(I.5)(D), THE HEALTH BENEFIT PLAN SHALL VERIFY AND DOCUMENT BEFORE USE THAT THE CRITERIA COMPLY WITH THE REQUIREMENTS OF SUBSECTION (5.5)(a)(I.5)(A) OF THIS SECTION.

(E) 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 SERVICES TO MAKE AVAILABLE THE COVERED SERVICE 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

1 OR DISORDER IN EACH CLASSIFICATION IN WHICH THE HEALTH BENEFIT
2 PLAN PROVIDES BENEFITS FOR ONE OR MORE MEDICAL CONDITIONS OR
3 SURGICAL PROCEDURES. A HEALTH BENEFIT PLAN DOES NOT PROVIDE
4 MEANINGFUL BENEFITS UNLESS IT PROVIDES BENEFITS FOR A CORE
5 TREATMENT FOR THAT CONDITION OR DISORDER IN EACH CLASSIFICATION
6 IN WHICH THE HEALTH BENEFIT PLAN PROVIDES BENEFITS FOR A CORE
7 TREATMENT FOR ONE OR MORE MEDICAL CONDITIONS OR SURGICAL
8 PROCEDURES. A CORE TREATMENT FOR A CONDITION OR DISORDER IS A
9 STANDARD TREATMENT OR COURSE OF TREATMENT, THERAPY, SERVICE,
10 OR INTERVENTION INDICATED BY GENERALLY ACCEPTED STANDARDS OF
11 BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE. IF
12 THERE IS NO CORE TREATMENT FOR A COVERED MENTAL HEALTH
13 CONDITION OR SUBSTANCE USE DISORDER WITH RESPECT TO A
14 CLASSIFICATION, THE HEALTH BENEFIT PLAN IS NOT REQUIRED TO PROVIDE
15 BENEFITS FOR A CORE TREATMENT FOR SUCH CONDITION OR DISORDER IN
16 THAT CLASSIFICATION, BUT MUST PROVIDE BENEFITS FOR SUCH CONDITION
17 OR DISORDER IN EVERY CLASSIFICATION IN WHICH MEDICAL OR SURGICAL
18 BENEFITS ARE PROVIDED.
19 (b) The commissioner:
20 (I) May adopt rules as necessary to ensure that this subsection
21 (5.5) is implemented and COMPLIANTLY administered; ~~in compliance with~~
22 ~~federal law and shall adopt rules to establish reasonable time periods for~~
23 ~~visits with a provider for treatment of a behavioral, mental health, or~~
24 ~~substance use disorder after an initial visit with a provider.~~
25 (II) MAY ADOPT RULES TO ESTABLISH CARRIER UTILIZATION
26 REVIEW COMPLIANCE IN ACCORDANCE WITH SUBSECTION (5.5)(a)(I.5) OF
27 THIS SECTION;

1 (III) MAY ADOPT RULES AS NECESSARY TO SPECIFY DATA TESTING
2 REQUIREMENTS TO DETERMINE PLAN DESIGN AND APPLICATION OF PARITY
3 COMPLIANCE FOR NONQUANTITATIVE TREATMENT LIMITATIONS USING
4 OUTCOMES DATA;
5 (IV) MAY ADOPT RULES TO SET STANDARD DEFINITIONS FOR
6 COVERAGE REQUIREMENTS, INCLUDING PROCESSES, STRATEGIES,
7 EVIDENTIARY STANDARDS, AND OTHER FACTORS;
8 (V) MAY ADOPT RULES TO ESTABLISH SPECIFIC TIMELINES FOR
9 CARRIER COMPLIANCE TO PROVIDE COMPARATIVE ANALYSIS INFORMATION
10 TO THE DIVISION FOR REVIEW, INCLUDING THE EFFECT OF A CARRIER'S
11 LACK OF SUFFICIENT COMPARATIVE ANALYSES TO DEMONSTRATE
12 COMPLIANCE; AND
13 (V) MAY ADOPT RULES TO ESTABLISH REASONABLE TIME PERIODS
14 AND DOCUMENTATION OF SUCH TIME PERIODS FOR VISITS WITH A
15 PROVIDER FOR TREATMENT OF A BEHAVIORAL, MENTAL HEALTH, OR
16 SUBSTANCE USE DISORDER AFTER AN INITIAL VISIT WITH A PROVIDER.
17 (c.3) THIS SUBSECTION (5.5) APPLIES TO ANY INDIVIDUAL, ENTITY,
18 OR CONTRACTING PROVIDER THAT PERFORMS UTILIZATION REVIEW
19 FUNCTIONS ON BEHALF OF A HEALTH BENEFIT PLAN.
20 (c.5) A CARRIER OFFERING A HEALTH BENEFIT PLAN SHALL NOT
21 ADOPT, IMPOSE, OR ENFORCE TERMS IN ITS POLICIES OR PROVIDER
22 AGREEMENT, IN WRITING OR IN OPERATION, THAT UNDERMINE, ALTER, OR
23 CONFLICT WITH THE REQUIREMENTS OF THIS SUBSECTION (5.5).
24 (d) As used in this subsection (5.5):
25 (I) "APPROPRIATE NONPARTICIPATING PROVIDER" MEANS A
26 PROVIDER WHO IS ACCESSIBLE AND HAS THE TRAINING AND EXPERIENCE
27 NECESSARY TO PROVIDE AGE-APPROPRIATE, MEDICALLY NECESSARY

1 TREATMENT OF A BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE
2 DISORDER.
3 (II) "Behavioral, mental health, and substance use disorder":
4 ~~(I)~~ (A) Means a condition or disorder, regardless of etiology, that
5 may be the result of a combination of genetic and environmental factors
6 and that falls under any of the diagnostic categories listed in the mental
7 disorders section of the most recent version of
8 ~~(A)~~ the "International Statistical Classification of Diseases and
9 Related Health Problems",
10 ~~(B)~~ the "Diagnostic and Statistical Manual of Mental Disorders",
11 or
12 ~~(C)~~ the "Diagnostic Classification of Mental Health and
13 Developmental Disorders of Infancy and Early Childhood"; and
14 ~~(II)~~ (B) Includes autism spectrum disorders, as defined in
15 subsection (1.4)(a)(III) of this section.
16 (III) "GENERALLY ACCEPTED STANDARDS OF BEHAVIORAL,
17 MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE" MEANS
18 STANDARDS OF CARE AND CLINICAL PRACTICE THAT ARE GENERALLY
19 RECOGNIZED BY HEALTH-CARE PROVIDERS PRACTICING IN RELEVANT
20 CLINICAL SPECIALTIES SUCH AS PSYCHIATRY, PSYCHOLOGY, CLINICAL
21 SOCIAL WORK, PSYCHIATRIC NURSING, ADDICTION MEDICINE AND
22 COUNSELING, AND BEHAVIORAL HEALTH TREATMENT. VALID,
23 EVIDENCE-BASED SOURCES REFLECTING GENERALLY ACCEPTED
24 STANDARDS OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE
25 DISORDER CARE INCLUDE PEER-REVIEWED SCIENTIFIC STUDIES AND
26 MEDICAL LITERATURE; CLINICAL PRACTICE GUIDELINES AND
27 RECOMMENDATIONS OF NONPROFIT HEALTH-CARE PROVIDER

1 PROFESSIONAL ASSOCIATIONS, SPECIALTY SOCIETIES, AND FEDERAL
2 GOVERNMENT AGENCIES; AND DRUG LABELING APPROVED BY THE FDA.
3 (IV) "MEDICALLY NECESSARY TREATMENT" MEANS A SERVICE OR
4 PRODUCT ADDRESSING THE SPECIFIC NEEDS OF A PATIENT FOR THE
5 PURPOSE OF SCREENING, PREVENTING, DIAGNOSING, MANAGING, OR
6 TREATING A BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER
7 OR ITS SYMPTOMS, INCLUDING MINIMIZING THE PROGRESSION OF THE
8 DISORDER, IN A MANNER THAT IS:
9 (A) IN ACCORDANCE WITH THE GENERALLY ACCEPTED STANDARDS
10 OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER CARE;
11 (B) CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY,
12 EXTENT, SITE, AND DURATION; AND
13 (C) NOT PRIMARILY FOR THE ECONOMIC BENEFIT OF THE INSURER
14 OR PURCHASER OR FOR THE CONVENIENCE OF THE COVERED PERSON,
15 TREATING PHYSICIAN, OR OTHER HEALTH-CARE PROVIDER.
16 (V) "UTILIZATION REVIEW" MEANS PROSPECTIVELY,
17 RETROSPECTIVELY, OR CONCURRENTLY REVIEWING AND APPROVING,
18 MODIFYING, DELAYING, OR DENYING REQUESTS BY HEALTH-CARE
19 PROVIDERS, COVERED PERSONS, OR THEIR AUTHORIZED REPRESENTATIVES
20 FOR COVERAGE, BASED IN WHOLE OR IN PART ON MEDICAL NECESSITY, OR
21 FOR OUT-OF-NETWORK SERVICES REQUIRED PURSUANT TO SUBSECTION
22 (5.5)(a)(V)(D) OF THIS SECTION.
23 (VI) "UTILIZATION REVIEW CRITERIA" MEANS AN EVALUATION OF
24 THE NECESSITY, APPROPRIATENESS, AND EFFICIENCY OF THE USE OF
25 HEALTH-CARE SERVICES, PROCEDURES, AND FACILITIES, INCLUDING
26 OUT-OF-NETWORK SERVICES REQUIRED PURSUANT TO SUBSECTION
27 (5.5)(a)(V)(D) OF THIS SECTION. "UTILIZATION REVIEW CRITERIA" DOES

1 NOT INCLUDE AN INDEPENDENT MEDICAL EXAMINATION PROVIDED FOR IN
2 ANY POLICY.
3 (e) (I) THIS SUBSECTION (5.5) DOES NOT EXPAND COVERAGE
4 REQUIREMENTS BEYOND THE STATE ESSENTIAL HEALTH BENEFITS
5 BENCHMARK PLAN AS REQUIRED PURSUANT TO 45 CFR 156.111.
6 (II) IF AN EXCLUSION FOR BEHAVIORAL HEALTH, MENTAL HEALTH,
7 OR SUBSTANCE USE DISORDER SERVICES IS NOT PERMITTED UNDER THE
8 MHPAEA, COVERAGE FOR THESE SERVICES MUST MEET THE
9 REQUIREMENTS OF THIS SUBSECTION (5.5).
10 **SECTION 2. Act subject to petition - effective date.** This act
11 takes effect January 1, 2026; except that, if a referendum petition is filed
12 pursuant to section 1 (3) of article V of the state constitution against this
13 act or an item, section, or part of this act within the ninety-day period
14 after final adjournment of the general assembly, then the act, item,
15 section, or part will not take effect unless approved by the people at the
16 general election to be held in November 2026 and, in such case, will take
17 effect on the date of the official declaration of the vote thereon by the
18 governor.