# DEPARTMENT OF REGULATORY AGENCIES

## Division of Insurance

### 3 CCR 702-4

### LIFE ACCIDENT AND HEALTH

## Amended Regulation 4-2-64

## CONCERNING MENTAL HEALTH PARITY IN HEALTH BENEFIT PLANS


Section 1 Authority
Section 2 Scope and Purpose
Section 3 Applicability
Section 4 Definitions
Section 5 Required Coverage
Section 6 Financial Requirements and Quantitative Treatment Limitations
Section 7 Non-Quantitative Treatment Limitations
Section 8 Denial of Benefits for Behavioral, Mental Health or Substance Use Disorders
Section 9 Annual Filings to the Commissioner
Section 10 Annual Reporting to the Commissioner
Section 11 Confidentiality
Section 12 Incorporation by Reference
Section 13 Severability
Section 14 Enforcement
Section 15 Effective Date
Section 16 History


**Section 1 Authority**

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-104(5.5)(b), 10-16-107(3)(a)(IV), 10-16-109, 10-16-113(10), 10-16-147(3), and 10-16-166(3), C.R.S.

**Section 2 Scope and Purpose**

The purpose of this regulation is to establish the requirements, processes, and forms to be utilized by carriers to ensure compliance with §§ 10-16-104(5.5) and 10-16-147, C.R.S., and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA as defined at § 10-16-102(43.5), C.R.S.).

This regulation adopts and reiterates the requirements of 45 C.F.R. 146.136(c)(4) and successor regulation 45 C.F.R 146.137(a)-(c) in accordance with § 10-16-104(5.5)(a)(V)(A), C.R.S. This regulation also adopts and reiterates the requirements of 45 C.F.R. 146.136(c)(2) and (c)(3) and successor regulations in accordance with § 10-16-104(5.5)(a)(V)(A), C.R.S.

**Section 3 Applicability**

This regulation applies to health benefit plans subject to the individual and group laws of Colorado, including non-grandfathered plans, short-term limited duration health insurance policies, and student health insurance coverage. This regulation does not apply to limited benefit plans, which are exempted from the definition of “health benefit plan” set forth in § 10-16-102(32)(b), C.R.S., and exclusions for coverage of specific mandated benefits as found at § 10-16-104, C.R.S.

The provisions of this regulation shall become effective consistent with the applicability requirements set forth in 45 C.F.R. § 146.136, 45 C.F.R. § 146.137, and 45 C.F.R. § 147.160. However, any requirements based only on Colorado law and annual Colorado reporting requirements shall become effective on the effective date of this regulation.

**Section 4 Definitions**

A. "Aggregate lifetime dollar limit" means, for the purposes of this regulation, a dollar limitation on the total amount of specified benefits that may be paid under a health benefit plan for any coverage unit.

B. "American Society of Addiction Medicine (ASAM) Criteria" means, for the purposes of this regulation, ASAM Criteria for Addictive, Substance-related, and Co-Occurring Conditions as referenced in § 10-16-104(5.5)(a)(I)(B), C.R.S.

C. "Annual dollar limit" means, for the purposes of this regulation, a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health benefit plan for any coverage unit.

D. "Autism spectrum disorder" shall have the same meaning as defined at § 10-16-104(1.4)(a)(III), C.R.S.

E. "Behavioral health benefits" means, for the purposes of this regulation, the benefits supplied for items or services for behavioral health conditions.

F. "Behavioral, mental health, and substance use disorder" shall have the same meaning as defined at § 10-16-104(5.5)(d), C.R.S.

G. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

H. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as defined at § 10-16-1303(14), C.R.S.

I. "Diagnostic and Statistical Manual of Mental Disorders (DSM)" shall have the same meaning as the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders defined in 45 C.F.R. § 146.136(a)(2).

J. "Evidentiary standards" are any evidence, sources, or standards that a health benefit plan or carrier considered or relied upon in designing or applying a factor with respect to a non-quantitative treatment limitation, including specific benchmarks or thresholds. Evidentiary standards may be empirical, statistical, or clinical in nature, and include: sources acquired or originating from an objective third party, such as recognized medical literature, professional standards and protocols (which may include comparative effectiveness studies and clinical trials), published research studies, payment rates for items and services (such as publicly available databases of the "usual, customary and reasonable" rates paid for items and services), and clinical treatment guidelines; internal carrier data, such as claims or utilization data or criteria for assuring a sufficient mix and number of network providers; and benchmarks or thresholds, such as measures of excessive utilization, cost levels, time or distance standards, or network participation percentage thresholds.

K. "Factors" are all information, including processes and strategies (but not evidentiary standards), that a health benefit plan or carrier considered or relied upon to design a non-quantitative treatment limitation, or to determine whether or how the non-quantitative treatment limitation applies to benefits under the plan or coverage. Examples of factors include, but are not limited to: provider discretion in determining a diagnosis or type or length of treatment; clinical efficacy of

any proposed treatment or service; licensing and accreditation of providers; claim types with a high percentage of fraud; quality measures; treatment outcomes; severity or chronicity of condition; variability in the cost of an episode of treatment; high cost growth; variability in cost and quality; elasticity of demand; and geographic location.

L. "FDA" means, for the purposes of this regulation, the Food and Drug Administration in the United States Department of Health and Human Services.

M. "Financial requirements" means, for the purposes of this regulation, the deductibles, copayments, coinsurance, or out-of-pocket maximums imposed under a health benefit plan. Financial requirements do not include aggregate lifetime or annual dollar limits.

N. "Health benefit plan" shall have the same meaning as defined at § 10-16-102(32), C.R.S.

O. "International Statistical Classification of Diseases and Related Health Problems" or "ICD)" shall have the same meaning as the World Health Organization's International Classification of Diseases defined in 45 C.F.R. § 146.136(a)(2).

P. "Material difference" means, for the purposes of this regulation, data-driven differences in access between mental health and substance use disorder benefits compared to medical and surgical benefits based on all relevant facts and circumstances.

Q. "Medical/surgical benefits" for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2).

R. "Mental health benefits" for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2), except for generally recognized independent standards of current medical practice shall also include The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as referenced in § 10-16-104(5.5)(d)(I)(C), C.R.S.

S. "Medication-Assisted Treatment (MAT)" shall have the same meaning as found at § 23-21-803(4), C.R.S.

T. "MHPAEA" shall have the same meaning as found at § 10-16-102(43.5) C.R.S.

U. "Participating provider" shall have the same meaning as found at § 10-16-104(46), C.R.S.

V. "Prior authorization" shall have the same meaning as found at § 10-16-112.5(7)(d), C.R.S.

W. "Processes" are actions, steps, or procedures that a health benefit plan or carrier uses to apply a non-quantitative treatment limitation, including actions, steps, or procedures established by the health benefit plan or carrier as requirements in order for a participant or beneficiary to access benefits, including through actions by a participant's or beneficiary's authorized representative or a provider or facility. Examples of processes include, but are not limited to: procedures to submit information to authorize coverage for an item or service prior to receiving the benefit or while treatment is ongoing (including requirements for peer or expert clinical review of that information); provider referral requirements that are used to determine when and how a participant or beneficiary may access certain services; and the development and approval of a treatment plan used in a concurrent review process to determine whether a specific request should be granted or denied. Processes also include the specific procedures used by staff or other representatives of a health benefit plan or carrier (or the service provider of a health benefit plan or carrier) to administer the application of non-quantitative treatment limitations, such as how a panel of staff members applies the non-quantitative treatment limitation (including the qualifications of staff involved, number of staff members allocated, and time allocated), consultations with panels of

experts in applying the non-quantitative treatment limitation, and the degree of reviewer discretion in adhering to criteria hierarchy when applying a non-quantitative treatment limitation.

X. "Provider" shall have the same meaning as found at § 10-16-104(56), C.R.S.

Y. "SERFF" means, for the purposes of this regulation, the NAIC System for Electronic Rate and Form Filing.

Z. "Short-term limited duration health insurance policy" and "short-term policy" shall have the same meaning as found at § 10-16-102(60), C.R.S.

AA. "Step therapy" shall have the same meaning as found at § 10-16-145(1)(g), C.R.S.

AB. "Strategies" are practices, methods, or internal metrics that a health benefit plan or carrier considers, reviews, or uses to design a non-quantitative treatment limitation. Examples of strategies include, but are not limited to: the development of the clinical rationale used in approving or denying benefits; the method of determining whether and how to deviate from generally accepted standards of care in concurrent reviews; the selection of information deemed reasonably necessary to make medical necessity determinations; reliance on treatment guidelines or guidelines provided by third-party organizations in the design of a non-quantitative treatment limitation; and rationales used in selecting and adopting certain threshold amounts to apply a non-quantitative treatment limitation, professional standards and protocols to determine utilization management standards, and fee schedules used to determine provider reimbursement rates, used as part of a non-quantitative treatment limitation. Strategies also include the method of creating and determining the composition of the staff or other representatives of a health benefit plan or carrier (or the service provider of a health benefit plan or carrier) that deliberates, or otherwise makes decisions, on the design of non-quantitative treatment limitations, including the health benefit plan or carrier's methods for making decisions related to the qualifications of staff involved, number of staff members allocated, and time allocated; breadth of sources and evidence considered; consultations with panels of experts in designing the non-quantitative treatment limitation; and the composition of the panels used to design a non-quantitative treatment limitation.

AC. "Student health insurance coverage" and "student health policy" shall have the same meaning as found at § 10-16-102(65), C.R.S.

AD. "Substance use disorder benefits" means for health benefit plans shall have the same meaning as 45 C.F.R. § 146.136(a)(2), except for generally recognized independent standards of current medical practice shall also include The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as referenced in § 10-16-104(5.5)(d)(I)(C), C.R.S.

AE. "Treatment limitations" include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations (such as standards related to network composition), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See Section 7 of this regulation for an illustrative, non-exhaustive list of non-quantitative treatment limitations.) A complete exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

**Section 5 Required Coverage**

A. Preventive Care and Access to Coverage

1. Pursuant to § 10-16-104(18)(b)(I), C.R.S., carriers must provide coverages for the total cost (without deductibles, copayments, or coinsurance) for the following:

    a. An unhealthy alcohol use screening for adults;

    b. A preventive screening for depression in adolescents and adults; and

    c. Perinatal maternal counseling interventions for persons at risk.

2. These benefits may be provided by a primary care provider, behavioral health care provider as defined at § 25-1.5-502(1.3), C.R.S., or mental health professional licensed or certified pursuant to Article 245 of Title 12.

B. Court-Ordered Treatment

1. Carriers shall provide coverage for court-ordered medically necessary services for behavioral, mental health, and substance use disorders, as specified in § 10-16-104.8, C.R.S., and for substance use disorders, as specified in § 10-16-104.7, C.R.S.

2. Nothing in this Section 5.B. prohibits a carrier from using appropriate disease management or utilization review protocols, as long as the protocols are no more stringent or restrictive than medical/surgical disease management or utilization review protocols.

C. Carriers shall provide coverage for medication-assisted treatment of substance use disorders as specified in § 10-16-148, C.R.S.

1. Carriers shall place at least one covered prescription medication approved by the FDA for the treatment of substance use disorder on the lowest tier of the drug formulary developed and maintained by the carrier.

2. Carriers shall not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.

3. Carriers shall not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

4. Carriers shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

D. A carrier that provides coverage under a health benefit plan for a drug used to treat a substance use disorder shall not require prior authorization, as defined in § 10-16-112.5(7)(d), for a drug based solely on the dosage amount.

E. Every health benefit plan subject to the requirements of § 10-16-104(5.5), C.R.S., shall:

1. Establish procedures to authorize treatment with a 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 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;

2. If a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within established time and distance standards, reimburse treatment or services for behavioral, mental health, or substance use disorders required to be covered pursuant to § 10-16-104(5.5), C.R.S., that are provided by a nonparticipating provider using the same methodology the carrier uses to reimburse covered medical services provided by nonparticipating providers and, upon request, provide evidence of the methodology to the covered person or provider.

F. For the treatment of substance use disorders, carriers shall use the American Society of Addiction Medicine (ASAM) criteria for the placement, medical necessity, and utilization management determinations, as specified in § 10-16-104(5.5)(a)(I)(B), C.R.S.

G. Carriers shall not utilize the body mass index (BMI), ideal body weight (IBW), or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the DSM.

The following factors, at a minimum, must be considered when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder:

1. The individual's eating behaviors;

2. The individual's need for supervised meals and support interventions;

3. Laboratory results, including but not limited to, the individual's heart rate, renal or cardiovascular activity, and blood pressure;

4. The recovery environment; and

5. Co-occurring disorders the individual may have.

H. Carriers shall provide meaningful benefits for any mental health or substance use condition in every benefit classification in which medical/surgical benefits are provided. A carrier does not provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification in which the 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 recognized independent standards of current medical practice.

**Section 6 Financial Requirements and Quantitative Treatment Limitations**

A. All health benefit plans subject to the individual and group laws of Colorado must comply with the financial requirements and quantitative treatment limitations specified in 45 C.F.R. 146.136(c)(2) and (c)(3).

B. A health benefit plan that provides both medical/surgical benefits and mental health or substance use disorder benefits shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. A carrier shall not impose any financial requirement or treatment limitation that is applicable only with respect to mental health or

substance use disorder benefits and not to any medical/surgical benefits in the same benefit classification.

C. A carrier shall not sell a health benefit plan or short term policy that fails to comply with Section 6 of this regulation, as specified in 45 C.F.R. § 146.136(c).

D. Calculation of Substantially All and Predominant Level Benefits

1. Carriers shall not use any financial requirement or quantitative treatment limitation unless the carrier can provide verification that the following conditions have been met:

a. Substantially All Test

(1) A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two thirds of all medical/surgical benefits in that classification.

(2) For the purposes of this regulation, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.

(3) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

b. Predominant Level Test

(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under Section 6.D.1.a, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(3) Carriers must follow the examples set forth 45 C.F.R. § 146.136 regarding the predominant level test.

c. Portion Based on Plan Payments

The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative.

d. Classification for Certain Thresholds

For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.

For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. The rules of this paragraph apply for any other thresholds at which the rate of the plan payment changes.

2. Substantially All and Predominant Level Test Requirements

a. The expected claim payments shall be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. If a carrier has sufficient plan-level claims data for a reasonable projection of expected claim payments, such claims data shall be used for the analysis.

Other reasonable claims data may be used to project expected claim payments only if there is insufficient plan-level claims data. The assumptions used in choosing a data set and making projections shall be submitted to the Division if plan-level claims data are not used.

A reasonable and credible method shall be used to project the expected claim payments for medical/surgical benefits when performing the financial requirement or quantitative treatment limitation analysis. The method shall use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice.

b. Carriers shall not consider estimated claims payments associated with behavioral, mental health, or substance use disorder benefits in the calculation.

c. Carriers shall consider all estimated claims payments applying to the deductible and out-of-pocket maximum when calculating the deductible and out-of-pocket maximum applicability in determining if the deductible and out-of-pocket maximum apply to substantially all of the claims.

E. Allowed Benefit Classifications

1. If a plan provides any benefits for a mental health condition or substance use disorder in any classification of benefits described in Section 6.E.2., it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical/surgical benefits are provided. For purposes of this paragraph, whether the benefits provided are meaningful benefits is determined in comparison to the benefits provided for mental 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 plan (or coverage) provides benefits for one or more medical conditions or surgical procedures. A plan (or coverage does not provide meaningful benefits under this paragraph unless it provides benefits for a core treatment for that condition or disorder in each classification in which the plan (or coverage) provides benefits for a core treatment for one or more medical conditions or surgical procedures. For purposes of this paragraph, a core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the plan (or coverage) 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/surgical benefits are provided). In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph apply separately with respect to that classification for all financial requirements or treatment limitations. The following classification of benefits are the only classifications used in applying the rules of this paragraph, in addition to the permissible sub-classifications described in Section 6.F.

2. The substantially all/predominant level test must be applied separately to the following six (6) classifications of benefits:

    a. Inpatient In-Network;

    b. Inpatient Out-of-Network;

    c. Outpatient In-Network;

    d. Outpatient Out-of-Network;

    e. Emergency care; and

    f. Prescription drugs.

F. Special Rules

Unless specifically permitted under this paragraph, sub-classifications are not permitted when applying the rules of paragraph D of this section.

1. If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in Section 7 (relating to requirements for non-quantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the

parity requirements of this paragraph with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

2. Multiple In-Network Tiers. If a carrier provides benefits through multiple tiers of in-network providers (such as an in- network tier of preferred providers with more generous cost-sharing to members than a separate in-network tier of participating providers), the carrier may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in Section 7 (such as quality performance and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the carrier may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph D of this section.

3. Sub-classifications permitted for office visits, separate from other outpatient services. For purposes of applying the financial requirement and treatment limitation rules of Section 6, a health benefit plan or carrier may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph D of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph are:

   a. Office visits (such as physician visits), and

   b. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

G. No separate cumulative financial requirements or cumulative quantitative treatment limitations

A carrier may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

H. Parity requirements with respect to aggregate lifetime and annual dollar limits.

1. Plan with no limit or limits on less than one-third of all medical/surgical benefits.

If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

2. Plan with a limit on at least two-thirds of all medical/surgical benefits.

If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either-

a. Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health benefits or substance use disorder benefits; or

b. Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively m on medical/surgical benefits.

3. Determining one-third and two-thirds of all medical/surgical benefits.

For purposes of this paragraph H, the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

4. Plans not described in paragraph H.1. or H.2.of this section

a. In general, a group health plan that is not described in paragraph H.1. or H.2.of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either:

(1) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance us disorder benefits; or

(2) Impose an aggregate of annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph. In addition, for purposes for determining weighted averages, any benefits that re not within a category that is subject to a separately-designed dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

b. For purposes of this paragraph H.4., the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph H.3. for determining one-third or two-thirds of all medical surgical benefits.

5. Nothing in this section shall prohibit a carrier from:

a. Providing some benefits that are subject to the deductible and other benefits that are not subject to the deductible within the same classification; or

b. Applying, separately, a deductible or out-of-pocket maximum that differs between the in-network and out-of-network benefit levels, as long as the same deductible or out-of-pocket that applies to behavioral, mental health, or substance use disorder benefits applies to medical/surgical benefits.

**Section 7 Non-Quantitative Treatment Limitations**

A. All health benefit plans subject to the individual and group laws of Colorado must comply with the non-quantitative treatment limitation requirements of 45 C.F.R. 146.136(c)(4) and successor regulation 45 C.F.R 146.137(a)-(c).

B. Carriers may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification that is more restrictive, as written or in operation, than the predominant nonquantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification. For purposes of this Section 7.B., a nonquantitative treatment limitation is more restrictive than the predominant nonquantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification if the health benefit plan or carrier fails to meet the requirements of Section 7.C. or D. In such a case, the health benefit plan or carrier will be considered to violate MHPAEA, and the nonquantitative treatment limitation may not be imposed by the health benefit plan or carrier with respect to mental health or substance use disorder benefits in the classification.

C. Requirements related to design and application of a nonquantitative treatment limitation.

1. A health benefit plan or carrier may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the health benefit plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits in the classification.

2. Prohibition on discriminatory factors and evidentiary standards.

For the purposes of determining comparability and stringency under Section 7.C.1, a health benefit plan or carrier may not rely upon discriminatory factors or evidentiary standards to design a non-quantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits.

a. Information, evidence, sources, or standards are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits if, based on all the relevant facts and circumstances, the information, evidence, sources, or standards systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits. For the purposes of this paragraph C.2.a, relevant facts and circumstances may include, but are not limited to, the reliability of the

source of the information, evidence, sources, or standards, including any underlying data; the independence of the information, evidence, sources, and standards relied upon; the analyses and methodologies employed to select the information and the consistency of their application; and any known safeguards deployed to prevent reliance on skewed data or metrics. Information, evidence, sources, or standards are not considered biased or not objective for this purpose if the health benefit plan or carrier has taken the steps necessary to correct, cure, or supplement any information, evidence, sources, or standards that would have been biased or not objective in the absence of such steps.

b. For purposes of Section 7.C.2, historical plan data or other historical information from a time when the plan or coverage was not subject to MHPAEA or was not in compliance with MHPAEA are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits, if the historical plan data or other historical information systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits, and the health benefit plan or carrier has not taken the steps necessary to correct, cure, or supplement the data or information.

c. For purposes of Section 7.C.2, generally recognized independent professional medical or clinical standards and carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits are not information, evidence, sources, or standards that are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits. However, health benefit plans and carriers must comply with Section 7, as applicable, with respect to such standards or measures that are used as the basis for a factor or evidentiary standard used to design or apply a non-quantitative treatment limitation.

D. Required use of outcome data.

1. To ensure that a nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification, in operation, is no more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical/surgical benefits in the classification, a health benefit plan or carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the non-quantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the health benefit plan's or carrier's evaluation. As part of its evaluation, the health benefit plan or carrier shall not disregard relevant outcomes data that it knows or reasonably should know suggest that a non-quantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits.

a. Relevant data generally. For the purposes of Section 7.D.1, relevant data could include, as appropriate, but are not limited to, the number and percentage of claims denials and any other data relevant to the nonquantitative treatment limitation required by Colorado law or private accreditation standards.

b. Relevant data for nonquantitative treatment limitations related to network composition. In addition to the relevant data set forth in Section 7.D.1.a, relevant data for nonquantitative treatment limitations related to network composition

could include, as appropriate, but are not limited to, in-network and out-of-network utilization rates (including data related to provider claims submissions), network adequacy matric (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (for comparable services and as benchmarked to a reference standards).

c. Unavailability of data

(1) If a health benefit plan or carrier newly imposes a non-quantitative treatment limitation for which relevant data is initially temporarily unavailable and the health benefit plan or carrier therefore cannot comply with Section 7.D.1, the health benefit plan or carrier must include in its comparative analysis, as required by Section 10.C.12., a detailed explanation of the lack of relevant data, the basis for the health benefit plan's or carrier's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed. Such health benefit plan or carrier also must comply with Section 7.D.1 as soon as practicable once relevant data becomes available.

(2) If a health benefit plan or carrier imposes a non-quantitative treatment limitation for which no data exist that can reasonably assess any relevant impact of the non-quantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits, the health benefit plan or carrier must include in its comparative analysis, as required by this Section 10.C.12., a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the non-quantitative treatment limitation's impact, why the nature of the non- quantitative treatment limitation prevents the health benefit plan or carrier from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the non-quantitative treatment limitation complies with Section 7. If a health benefit plan or carrier becomes aware of data that can reasonably assess any relevant impact of the non-quantitative treatment limitation, the health benefit plan or carrier must comply with Section 7.D.1.as soon as practicable.

(3) Sections 7.D.1.c.(1)-(2) of this section shall only apply in very limited circumstances and, where applicable, shall be construed narrowly.

2. Material differences. To the extent the relevant data evaluated under Section 7.D.1. suggest that the non-quantitative treatment limitation contributes to material differences in access benefits in a classification, such differences will be considered a strong indicator that the health benefit plan or carrier violates this Section 7.

a. Where the evaluated relevant data. suggest that the non-quantitative treatment limitation contributes to material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits in a classification, the health benefit plan or carrier must take reasonable action, as necessary, to address the material differences to ensure compliance, in operation, with Section 7. and must document the actions that have been or are being taken by the health benefit plan or carrier to address material differences in access to mental health or substance use disorder benefits, as compared to medical/surgical benefits, as required by Section 10.C.12.

b. For purposes of this Section 7.D.2, relevant data are considered to suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits if, based on all relevant facts and circumstances, and taking into account the considerations outlined in this Section 7.D.2.b, the difference in the data suggests that the nonquantitative treatment limitation is likely to have a negative impact on access to mental health or substance use disorder benefits compared to medical/surgical benefits.

(1) Relevant facts and circumstances, for purposes of this Section 7.D.2.b may include, but are not limited to, the terms of the nonquantitative treatment limitation at issue, the quality or limitations of the data, casual explanations and analyses, evidence as to the recurring or non-recurring nature of the results, and the magnitude of any disparities.

(2) Differences in access to mental health or substance use disorder benefits attributable to generally independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent fraud or abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits, which are used as the basis for a factor or evidentiary standard used to design or apply a nonquantitative treatment limitation, are not considered to be material for purposes of this Section 7.D.2. To the extent a health benefit plan or carrier attributes any differences in access to the application of such standards or measures, the health benefit plan or carrier must explain the bases for that conclusion in the documentation prepared under Section 10.C.12.

3. Nonquantitative treatment limitations related to network composition. For purposes of applying Section 7.D with respect to nonquantitative treatment limitations related to network composition, a health benefit plan or carrier must collect and evaluate relevant data in a manner reasonably designed to assess the aggregate impact of all such nonquantitative treatment limitations on access to mental health and substance use disorder benefits and medical/surgical benefits. Examples of possible actions that a health benefit plan or carrier could take to comply with the requirement under this Section 7.D.2.a to take reasonable action, as necessary, to address any material differences in access with respect to non-quantitative treatment limitations related to network composition to ensure compliance with Section 7, include, but are not limited to:

a. Strengthening efforts to recruit and encourage a broad range of available mental health and substance use disorder providers and facilities to join the carrier's network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network;

b. Expanding the availability of telehealth arrangements to mitigate any overall mental health and substance use disorder provider shortages in a geographic area

c. Providing additional outreach and assistance to participants and beneficiaries enrolled in the health benefit plan or coverage to assist them in finding available in-network mental health and substance use disorder providers and facilities; and

d. Ensuring that provider directories are accurate and reliable.

E. Illustrative, non-exhaustive list of non-quantitative treatment limitations. Non-quantitative treatment limitations include, but are not limited to:

1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative.

2. Utilization management protocols, including but not limited to prior authorization, concurrent review, and retrospective review.

3. Step therapy, fail-first, or the refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective.

4. Exclusions based on failure to complete a course of treatment.

5. Restrictions based on:

   a. Geographic location;

   b. Facility type;

   c. Provider specialty; and

   d. Other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

6. Formulary design for prescription drugs.

7. Network tier design (when the plan has multiple network tiers).

8. Standards related to network composition, including but not limited to:

   a. Standards for provider and facility admission to participate in a network or for continued network participation, including recruitment, retention, and contract negotiation processes;

   b. Methods for determining reimbursement rates;

   c. Credentialing standards, and

   d. Procedures for ensuring the network includes an adequate number of providers and facilities to provide services under the plan or coverage;

9. Methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates.

F. Non-Quantitative Treatment Limitation Examples

1. Pursuant to § 10-16-104(5.5)(a)(V)(A), C.R.S, carriers must comply with the non-quantitative treatment limitation illustrative examples set forth in 45 C.F.R. § 146.136.

2. Carriers shall not use the following medical management processes or strategies when applying limitations to behavioral, mental health, and substance use disorder benefits:

a. The carrier routinely approves a number of days without a treatment plan for medical/surgical inpatient, in-network, services, but approves, on a routine basis, a lesser number of days without a treatment plan for behavioral, mental health, and substance use disorders, inpatient-in-network.

b. The carrier applies concurrent review to inpatient, in-network stays with various lengths of stay due to the medical condition, but reviews all behavioral, mental health, and substance use disorder inpatient, in-network stays using a more restrictive review criteria, reviewing the stay more frequently in all cases than commonly used for medical/surgical benefits.

c. Location of Services

(1) The carrier allows for out-of-state treatment of medical/surgical services, but does not permit out-of-state treatment for behavioral, mental health, and substance use disorder services; or

(2) Permits access to an out-of-network hospital for medical/surgical services, but does not permit access to a non-network hospital for behavioral, mental health, and substance use disorders, when the plan covers non-network services.

d. The carrier does not apply a payment reduction penalty to outpatient medical/surgical services that do not have prior authorization, but applies a penalty to outpatient behavioral, mental health, and substance use disorder benefits when no prior authorization has been obtained.

e. Employee Assistance Programs (Group Plans Only)

In the event that an employer maintains both a major medical plan and an Employees Assistance Program, and the Employee Assistance Program provides a limited number of mental health or substance use disorder counseling sessions that are not significant benefits in the nature of medical care, the carrier requires that the member utilize the available Employee Assistance Program benefits prior to utilizing the behavioral, mental health, and substance use disorder benefits under the group plan. The carrier does not require the member to utilize the Employee Assistance Program for any medical/surgical benefits prior to utilizing the group plan.

f. Within the same classification, the carrier applies more restrictive prior authorization requirements in operation for mental health, behavioral health, and substance use disorder benefits than medical/surgical benefits.

g. Within the same classification, the carrier applies more restrictive peer-to-peer review medical necessity standards in and/or deviates from independent professional medical and clinical standards in operation for mental health, behavioral health, and substance use disorder benefits than for medical/surgical benefits.

h. Within the same classification, the carrier applies incomparable and more stringent methods for determining reimbursement rates in operation for mental health, behavioral health, and substance use disorder benefits than for medical/surgical benefits.

i. Within the same classification, the carrier uses more restrictive network admission standards for mental health, behavioral health, and substance use disorder providers than for medical/surgical benefits providers.

j. Within the same classification, in operation, the carrier's exclusions for experimental or investigative treatment are more restrictive when applied to behavior analysis (ABA) therapy for autism spectrum disorder than for a comparable medical/surgical condition.

3. Within the same prescription drug classification, carriers shall not use the following pharmacy benefit design when applying limitations to behavioral, mental health, and substance use disorder benefits:

a. Carrier formulary design for coverage of prescription drugs for medical/surgical conditions is based on FDA approval, clinical studies, peer-reviewed medical literature, recommendations of experts with necessary training and experience and other medical decision criteria which are routinely provided, whereas the exclusion of behavioral, mental health, and substance use disorder drugs is only based on the side effects reported as a part of clinical studies.

b. A carrier regularly provides coverage for medical/surgical prescription drugs on all four (4) tiers of a four (4) tier formulary design, but places all drugs for the treatment of behavioral, mental health, and substance use disorders on the two (2) highest tiers, without regard to it being generic, preferred brand name or non-preferred brand name.

4. Carriers shall not use the following network designs when applying limitations to behavioral, mental health, and substance use disorder benefits for the inpatient, in-network and outpatient, in-network classifications:

a. The carrier regularly allows licensed non-M.D. providers into the network who treat medical/surgical conditions while not permitting licensed non-M.D. providers into the network who primarily treat behavioral, mental health, or substance use disorders.

b. The carriers regularly admits into the network and reimburses for pre-licensure, provisional, and/or delegated medical/surgical providers, while not admitting into the network and reimbursing for pre-licensure, provisional, and/or delegated mental health, behavioral health, and substance use disorder providers.

c. The carrier regularly negotiates rates with a medical/surgical provider while not regularly negotiating rates with behavioral, mental health, and substance use disorder providers.

5. The items in this section are not an exhaustive list of non-quantitative treatment limitation violations.

**Section 8 Denial of Benefits for Behavioral, Mental Health or Substance Use Disorders**

A. Carriers shall provide consumers with written notice of the denial when denying benefits for the treatment of behavioral, mental health, or substance use disorders that explicitly provides the reason for denial.

B. Carriers shall provide the following language on any adverse determination of benefits for behavioral, mental health, or substance use disorders as required by § 10-16-113, C.R.S.:

"This plan is subject to the protections provided under the Mental Health Parity and Addiction Equity Act (MHPAEA). Coverage provided for mental health and substance use disorders must be comparable to services covered under the medical benefits available on this plan. If you believe that your rights under MHPAEA have been violated, you may contact the Office of the Ombudsperson for Behavioral Health Access to Care at 303-866-2789 or at ombuds@bhoco.org, or the Division, at Colorado Division of Insurance, Consumer Services, 1560 Broadway, Ste. 850, Denver, CO 80202, dora_insurance@state.co.us or 303-894-7490 or 800-930-3745 (in-state, toll-free).

You may also request a copy of the medical necessity criteria for any behavioral, mental health, or substance use disorder benefits, and it will be provided to you at no additional cost."

**Section 9 Annual Filings to the Commissioner**

A. As part of their annual health benefit plan filings, carriers shall provide the financial requirements and quantitative treatment limitation annual compliance documents, as detailed in this section.

B. Timing and Format of Filings

1. Carriers offering plans in the non-grandfathered individual and small group markets shall submit fully completed "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classification" documents by the date designated by the Division for annual filings. Carriers are required to use the template provided in SERFF to complete the "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classification" submissions.

2. Carriers offering plans in the non-grandfathered large group, student health policy, and short-term limited duration policy lines of business shall submit fully completed the "Financial Requirements Attestation" and "Financial Requirements and Quantitative Treatment Limitation Classifications" documents no later than March 1 of each year and prior to the submission of any rates, as applicable, for an upcoming plan year.

3. Carriers shall submit the completed "Financial Requirements Attestation" and "Quantitative Treatment Limitation Classifications" in SERFF as an "Annual MHPAEA Compliance Statement" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing.

4. Carriers shall use "On Approval" for the "Implementation Date" in SERFF.

5. Carriers shall use "File and Use" for the "Requested Filing Mode" in SERFF.

6. Carriers shall provide a filing description, including the plan year the filing will support.

C. Attestations

Carriers shall attest that all plans meet the requirements of § 10-16-104(5.5), C.R.S., and Colorado Insurance Regulation 4-2-64, in that all benefits associated with behavioral, mental health and substance use disorder meet all of the requirements of Colorado and federal law. Carriers must also attest to the following:

1. The plan meets the requirements of Section 6 of this regulation concerning financial requirements and quantitative treatment limitations.

2. The plan meets the requirements of Section 7 of this regulation concerning non-quantitative treatment limitations;

3. The coverage for autism spectrum disorders may not be subject to copayments, coinsurance, or deductibles that are less favorable than those applied to physical illness for the following services:

   a. Evaluation and assessment services;

   b. Habilitative benefits, including occupational therapy, physical therapy and speech therapy;

   c. Rehabilitative benefits, including occupational therapy, physical therapy and speech therapy;

   d. Pharmacy care and medication, if covered by the health benefit plan;

   e. Psychiatric care;

   f. Psychological care, including family counseling; and

   g. Therapeutic care.

4. The expected claim payments utilize a reasonable and credible method to determine the estimated claim payments associated with the medical/surgical benefits that are subject to a financial requirement or quantitative treatment limitation. The method utilized must conform to the Actuarial Standards of Practice.

5. The attestation shall be signed by an actuary and the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, chief executive officer, chief financial officer, chief operating officer, general counsel or other person, with documentation showing that the person has been appointed a company officer by the board of directors.

D. Quantitative Treatment Limitation Classifications:

1. Carriers shall provide Quantitative Treatment Limitation Classifications for the following plans:

   a. For individual and small group plans, carriers shall provide the required calculations for plans identified by the Division, which are chosen upon submission of reasonable modifications filings. The Division may increase the number of plans reviewed upon binder submissions. Carriers shall be notified of such via SERFF.

   b. For large group, student health policies and short-term limited duration policies, carriers shall provide the required calculations for the top ten (10) plan designs or top twenty percent (20%) of plan designs by premium volume, whichever is greater provided.

2. Carriers shall provide the classification of all benefits, except emergency room and prescription drugs, provided by the plan as: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; or outpatient, out-of-network. If the carrier sub-classifies the outpatient benefits, the carrier shall specify which of the outpatient benefits is considered an “Office Visit” or is included in the “All Other Outpatient Items and Services” category. Carriers shall not subclassify outpatient benefits using any other classes other than “Office Visits” and “All Other Outpatient Items and Services.”

3. Carriers shall provide the copay or coinsurance amount that applies to each of the benefits. Carriers shall also identify whether the deductible, if any, applies to the benefit.

4. Carriers shall provide the expected claims payments for all medical/surgical benefits provided by the plan.

5. Carriers shall not include expected claim payments for any behavioral, mental health, or substance use disorder benefits in the Quantitative Treatment Limitation Classification, including applied behavioral analysis therapy for autism spectrum disorders.

6. If the carrier utilizes multiple in-network tiers, the carrier shall supply two (2) versions of the "Quantitative Treatment Limitation Classifications" worksheet, identifying the template to which the tier applies.

E. The signatures required by this Section 9 must be an original or valid electronic signature of the person signing. Signature stamps, photocopies or a signature on behalf of the authorized signer are not acceptable. Electronic signatures shall be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations.

**Section 10 Annual Reporting to the Commissioner**

A. Carriers shall submit each of the treatment limitation templates as listed in this Section 10 to the Commissioner annually.

B. Timing and Format of Reporting

1. Carriers offering plans in the non-grandfathered individual, small group, and large group markets, student health policies, and short-term limited duration policy lines of business will submit the following, fully-completed reports no later than March 1 of each year. Data will be collected and reported to the Division that pertains to the January 1 through December 31 reporting period annually in the following templates:

a. NQTL Identification and Classification (includes Medical Management)

b. NQTL Verifications

c. Prior Authorization and Concurrent Review

d. Out-of-Network and Gap Exception Utilization Data

e. Provider Network Engagement and Availability

f. Office Visit In-Network Allowed Rates Analysis

g. Provider Credentialing

h. Confidential Network Development Medicare

i. ASAM Criteria Utilization

j. Eating Disorder BMI/IBW

k. Pharmacy Medical Management

l. Colorado NQTL Comparative Analysis Six-Step Reporting

2. Carriers shall submit the completed reports using the templates provided in SERFF as an "Annual MHPAEA Compliance Statement" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing. Carriers are required to provide a comprehensive inventory of covered services within each classification or sub-classification of benefits for each health benefit plan offered by the carrier during the reporting period.

3. Carriers shall use "On Approval" for the "Implementation Date" in SERFF.

4. Carriers shall use "File and Use" for the "Requested Filing Mode" in SERFF.

5. Carriers shall provide a filing description, including the plan or benefit year of the data being reported.

C. Non-Quantitative Treatment Limitation Reporting Templates

1. NQTL Identification and Classification (includes Medical Management)

a. Carriers shall complete and provide the template to identify all non-quantitative treatment limitations as required by C.R.S. § 10-16-147(2)(c).

b. Carriers must complete one template for each applicable market level for all plans within that market level that use the same processes, standards, and benefit classification structure for application of non-quantitative treatment limitations. The carrier must list each covered service, classifying it as medical/surgical, mental health, or substance use disorder, and specify the applicable NQTLs for each benefit classification or subclassification.

2. NQTL Verifications

a. Carriers shall complete one NQTL Verification template for each market offered by the carrier, including a separate NQTL verification template for Colorado Option Standardized Plans offered in the individual and small group markets.

b. Carriers shall provide the following data by medical/surgical, behavioral health, mental health or substance use disorder category and by classification.

(1) Processed claim counts for covered benefits and

(2) Non-duplicate, unique claim counts. Carriers shall specify the reasons for claim actions, categorized by Claim Adjustment Group Codes and Claim Adjustment Reasons Codes.

3. Prior Authorization and Concurrent Review

a. Carriers shall complete a Prior Authorization and Concurrent Review Data template for each applicable market level and including data for all plans within that market level that use the same processes, standards, and benefit classification structure.

b. Carriers shall provide the number of all in-network and out-of-network prior authorization requests and concurrent reviews requested, irrespective of service delivery or claims submission, during the reporting period.

c. Carries shall categorize the review requests as medical/surgical, mental health, or substance use disorder based on the requested review of the primary diagnosis.

d. Carrier shall provide the outcomes of prior authorization review requests and concurrent review requests.

4. Out-of-Network and Gap Exception Utilization Data

a. Carriers shall complete one Out-of-Network and Gap Exception Utilization Data template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall provide claims data for in-network, out-of-network, and network gap exception claims submitted.

5. Provider Network Engagement and Availability

a. Carriers shall complete one Provider Network Engagement and Availability template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall report data on the number and types of providers listed as participating in the network at any time during the reporting period. Carriers shall report claim submission data during the reporting period for in-network providers.

6. Office Visit In-Network Allowed Rates Analysis

a. Carriers shall complete one Office Visit In-Network template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall report weighted average allowed amounts for in-network Mental Health/Substance Use Disorder providers and Medical/Surgical providers using claims data from January 1 to December 31 of the calendar year preceding the filing submission date by CPT code, including:

(1) 99213

(2) 99214

(3) 90834

(4) 90837

c. Carriers shall also provide their Standard Provider Fee Schedule(s) for the specific CPT codes applicable during the same review period.

7. Provider Credentialing

a. Carriers shall complete one Provider Credentialing template for each applicable market level and include all plans within that market level that use the same processes and standards, for application of the NQTLs of Provider Credentialing

b. Carriers shall report the total number of initial provider credentialing and recredentialing applications received during the reporting period.

c. For all credentialing and recredentialing applications, carriers shall report the total number of pending applications, closed applications, outcome types, and processing times.

8. Confidential Network Development Medicare

a. Carriers shall complete one Confidential Network Development Medicare template for each network offered by the Carrier, including the Colorado Option Standardized Plans networks.

b. Carriers shall provide allowable rates for all medical/surgical, mental health, and substance use disorder benefits by provider type and service location by the following:

(1) Weighted average

(2) 25th, 50th, 75th, and 95th percentiles

(3) 50th percentile as percentage of Medicare allowable amount

c. Carriers shall report the weighted average allowed reimbursement rates based on in-network claims by procedure code, and the 25th, 50th, 75th and 95th percentiles of the allowed amounts for procedure codes.

d. Carriers shall utilize the Medicare Physician Fee Schedule (MPFS) for the reporting period year as a basis for professional fee Medicare allowable amounts.

e. Carriers shall provide an explanation of the method utilized to determine Medicare allowable amounts for facility services.

9. ASAM Criteria Utilization

a. Carriers shall complete an ASAM Criteria Utilization template for each applicable market level for all plans within that market level that use the same processes and standards related to ASAM medical necessity criteria.

b. Carriers shall provide information regarding compliance with § 10-16-104(5.5)(a)(I)(B), C.R.S. It shall include the following:

(1) Utilization of the treatment identified in § 10-16-104(5.5)(a)(I)(B), C.R.S., in policy and operation, in accordance with generally accepted standards of care;

(2) Modifications to the treatment identified in § 10-16- 104(5.5)(a)(I)(B), C.R.S., and rationale for such;

(3) Utilization of criteria in addition to the treatment identified in § 10- 16-104(5.5)(a)(I)(B), C.R.S., and rationale for such;

(4) Application of the treatment identified in § 10-16- 104(5.5)(a)(I)(B), C.R.S., at various levels of care and review;

(5) Reviewing training and preparedness to assess the treatment identified in § 10-16-104(5.5)(a)(I)(B), C.R.S., in medical determinations; and

(6) Information regarding claim handling of substance use disorder benefits.

10. Eating Disorder BMI/IBW

a. Carriers shall complete an Eating Disorder BMI/IBW template at each applicable market level for all plans within that market level that use the same processes and standards related to eating disorder medical necessity criteria.

b. Carriers shall attest to and validate compliance with §§ 10-16-166(1) and (2), C.R.S., including the absence of body mass index (BMI) or ideal body weight (IBW) criteria utilization or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder.

c. Carriers shall include the minimum factors set forth in § 10-16-166(2), C.R.S. used when determining medical necessity of the appropriate level of care for an individual diagnosed with an eating disorder.

11. Pharmacy Medical Management

a. Carriers shall complete a Pharmacy Medical Management template for each applicable market level and include data for all plans within that market level that use the same processes and standards for pharmacy medical management.

b. Carriers shall provide the number of all in-network and out-of-network requests for pharmaceuticals regardless of whether the medication was dispensed or claim was submitted, during the reporting period.

c. Carriers shall categorize the review requests as medical/surgical, mental health, or substance use disorder based on the medication's indication and use.

d. Carriers shall further define and report on the reasons for pharmacy request denials including prior authorization denials, and formulary exception denials.

12. Colorado NQTL Comparative Analysis Six-Step Reporting

a. Carriers shall provide the Colorado NQTL Comparative Analysis Six-Step Reporting template to demonstrate performance and documentation of the Comparative Analysis required by 42 U.S.C. § 300gg-26(a)(8)(A), 45 C.F.R. 146.137(c), and § 10-16-147(2)(d), C.R.S. Carriers shall provide one template for each NQTL specific to each applicable benefit classification and may include all plans within the market that utilize the same processes, standards, and benefit classification structure. If the carriers' plans in the same market utilize different processes, standards, or benefit classification structures, then separate templates must be submitted. The analysis in the template must address all non-quantitative treatment limitations within each benefit classification or subclassification identified by the carrier in the NQTL Identification and Classification (includes Medical Management) Template, and must include, at minimum, the following non-quantitative treatment limitations as written and in operation:

(1) Medical necessity criteria

(2) Prior authorization

(3) Concurrent review

(4) Provider reimbursement

(5) Network development and adequacy

(6) Network admission and credentialing

(7) Retrospective review

(8) Fail first and step therapy

(9) Facility/Provider Type Restrictions

(10) Geographic Restrictions

b. Carriers shall explain the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical/surgical benefits within the corresponding classification of benefits.

c. Carriers are required to complete the templates identified in Section 10.C.2 of this regulation and address any comparative disparities in the in-operation comparative analysis related to the specific NQTL.

d. The Comparative Analysis submission shall, at minimum:

(1) Provide a detailed definition of the NQTL and describe the specific coverage terms, plan language, and procedures as applied to mental health, substance use disorder, and medical or surgical benefits.

(2) Provide a listing of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies. Carriers shall list all pertinent plan documents that outline the application of the NQTLs.

(3) Identify the factors relied upon in the design and application of NQTLs to the services in the specific benefit classification or subclassification for both mental health/substance use disorder and medical/surgical benefits;

(4) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation;

(5) Provide a comprehensive assessment and comparative analyses, including any results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply to each non-quantitative treatment limitation for benefits for behavioral, mental health, and substance use disorders are comparable

to, and are applied no more stringently than, the processes and strategies used to design and apply to each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply to each non-quantitative treatment limitation for medical and surgical benefits;

(6) Provide a comprehensive assessment and comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply to each non-quantitative treatment limitation, in operation, for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply to each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(7) Disclose the specific findings and conclusions reached by the carrier that the results of the analyses indicate that each health benefit plan offered by the carrier complies with § 10-16-104(5.5), C.R.S., and the MHPAEA.

e. Carriers shall have the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, chief executive officer, chief financial officer, chief operating officer, general counsel or other person, with documentation showing that the person has been appointed a company officer by the board of directors certify that the information contained in the comparative analyses is accurate and in compliance with this regulation.

f. The signatures required by this Section 10 must be an original or valid electronic signature of the person signing. Signature stamps, photocopies or a signature on behalf of the authorized signer are not acceptable. Electronic signatures shall be in compliance with § 24-71.3-101 et seq., C.R.S., and applicable regulations.

**Section 11 Confidentiality**

A. All mental health parity filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as the calculations of “substantially all” and “predominant” tests; narratives regarding any review standard the carrier may use; the attestations; or any other such documents as required in this regulation as confidential. Carriers must submit the confidential exhibits separately in SERFF, which must be indicated as such by the confidential icon in SERFF. Non-confidential information must be in a separate SERFF component.

B. Nothing in this section shall prohibit a carrier from redacting information in public documents that is confidential. Carriers shall submit a redacted and unredacted version of any documents.

C. The Division considers the information submitted in the Non-Quantitative Treatment Limitations: Confidential Network Development Questionnaire as confidential, pursuant to § 24-72-204, C.R.S.

D. A “Confidentiality Index” must be completed if the carrier desires confidential treatment of any information submitted, as required in this regulation. The Division will evaluate the reasonableness of any requests for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected.

**Section 12 Incorporation by Reference**

Actuarial Standards of Practice shall mean the Actuarial Standards of Practice as published by the Actuarial Standards Boards on the effective date of this regulation and does not include later amendments to or editions of the Actuarial Standards of Practice. Actuarial Standards of Practice may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of Actuarial Standards of Practice may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A charge for certification may apply. A copy may also be obtained online at http://www.actuarialstandardsboard.org/standards-of-practice/.

45 C.F.R. § 146.136 shall mean 45 C.F.R. § 146.136 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 146.136. A copy of 45 C.F.R. § 146.136 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 146.136 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 146.137 shall mean 45 C.F.R. § 146.137 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 146.137. A copy of 45 C.F.R. § 146.137 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 146.137 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 147.160 shall mean 45 C.F.R. § 147.160 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.160. A copy of 45 C.F.R. § 147.160 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.160 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

**Section 13 Severability**

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

**Section 14 Enforcement**

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in § 10-3-1108, C.R.S., may be applied.

**Section 15 Effective Date**

This regulation shall become effective on January 30, 2025, except as follows:

A. The requirements in Sections 5.H. and 6.E relating to the provision of meaningful benefits pursuant to 45 C.F.R. § 146.136(c)(2)(ii)(A) shall become effective for health benefit plans issued on or after January 1, 2026.

B. The requirements in Section 7.C.2, addressing the prohibition on discriminatory factors and evidentiary standards in the design and application of non-quantitative treatment limitations,

pursuant to 45 C.F.R. § 146.136(c)(4)(i)(B), and § 146.137(c)(2)(ii)(C) shall become effective for health benefit plans issued on or after January 1, 2026.

C. The requirements in Section 7.D, pertaining to the required use and evaluation of outcome data under 45 C.F.R. § 146.136(c)(4)(iii), § 146.137 (c)(5)(i)(C) and (D), and (c)(5)(ii) through (v) shall become effective for health benefit plans issued on or after January 1, 2026.

D. Until the applicability dates set forth in the section, health benefit plans and carriers shall continue to comply with Regulation 4-2-64 effective June 1, 2021.

**Section 16 History**

Emergency regulation 19-E-02 effective June 13, 2019.

Emergency regulation 19-E-04 effective October 10, 2019.

Regulation effective February 1, 2020.

Amended Regulation effective June 1, 2021.

Amended Regulation effective January 30, 2025.