COLORADO
Department of Regulatory Agencies
Division of Insurance

Health & Human Services Committee
House of Representatives
Colorado General Assembly
200 East Colfax
Denver, Colorado 80203

Health & Human Services Committee
Colorado State Senate
Colorado General Assembly
200 East Colfax
Denver, Colorado 80203

May 28, 2025

Dear Representatives and Senators,

Under the leadership of Governor Polis, the Colorado Division of Insurance (the Division), part of the Department of Regulatory Agencies, continues to make progress in its efforts to ensure that Colorado consumers have access to quality and affordable behavioral health care with their private insurance coverage. We are pleased to share this report that highlights our activities to implement the Behavioral Health Care Coverage Modernization Act and enforce mental health parity in the private insurance market in Colorado.

Pursuant to § 10-16-147, C.R.S., this report addresses the methodology used to evaluate health insurance carrier compliance with mental health parity laws and regulations, market conduct examination activities, and corrective actions taken to protect Colorado consumers. In addition to these statutory requirements, it summarizes other Division activities undertaken in the last year to expand behavioral health education and support resources for consumers and providers, ensure affordable cost-sharing for services, and further strengthen its enforcement operations to ensure access to life-saving behavioral health care.

Thank you for the opportunity to share with you our efforts to enforce mental health parity. Please do not hesitate to contact me should you have questions or comments about the information contained in this report.

Sincerely,

Michael Conway
Commissioner of Insurance

COLORADO

Department of Regulatory Agencies

Division of Insurance

Annual Mental Health Parity Report: The Colorado Division of Insurance's Implementation and Enforcement Actions

In accordance with § 10-16-147, C.R.S., Presented to:

Health & Human Services Committee: Colorado House of Representatives

Health & Human Services Committee: Colorado State Senate

May 28, 2025

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Executive Summary

The Colorado Division of Insurance (the Division) presents its activities related to the Behavioral Health Care Coverage Modernization Act in its sixth year of implementation, which occurred from June 1, 2024 through May 31, 2025. It summarizes data collection and analysis processes, enforcement actions, and consumer and provider resource creation to ensure quality and affordable mental health and substance use disorder (SUD), also called "behavioral health," coverage in the Colorado commercial insurance market.
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) codified the federal requirement of insurance companies to cover behavioral health and physical health care comparably, which is measured by quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs), and coverage was further expanded by Patient Protection and Affordable Care Act of 2010 (ACA). The Behavioral Health Care Coverage Modernization Act codified federal requirements into Colorado state law in 2019 and granted the Division additional capacity and authority to enforce the requirements, primarily through Colorado Insurance Regulation 4-2-64 Concerning Mental Health Parity in Health Benefit Plans.

This report summarizes the Division's enforcement efforts since the last annual report submitted to the Colorado General Assembly on June 1, 2024. Such efforts include:

- Reviewing QTLs, cost-sharing structures, and NQTLs applied by carriers across the private commercial market to ensure that mental health and substance use disorder (MH/SUD) benefits are offered in compliance with federal and state parity requirements and are no more restrictive than those applied to medical/surgical benefits;
- Launching market conduct examinations (MCEs) to assess carrier MHPAEA compliance;
- Increasing transparency of coverage requirements through carriers' consumer-facing policy documents;
- Expanding consumer-oriented public education and insurance literacy resources on the Division's website; and
- Expanding behavioral health provider resources and a complaint tracking system to address provider challenges with commercial market participation.

The activities highlighted in this report illustrate some of the momentum that continues to build in the state. The Division looks forward to continuing work with the Legislature, state agencies, health insurance carriers, service organizations, health care providers, and communities in future efforts to ensure that the behavioral health system works for every Coloradan.

Introduction

The Colorado Division of Insurance welcomes the opportunity to share a summary and update of its activities related to HB19-1269, the Behavioral Health Care Coverage Modernization Act, which addresses issues related to mental health parity and coverage of mental health, behavioral health, and substance use disorder (SUD) services with the Health and Human Services Committee of the Colorado House of Representatives and the Health and Human Services Committee of the Colorado State Senate. This report focuses on private health insurance and the Division of Insurance's ("the Division") implementation activities in the Act's sixth year of implementation, which occurred from June 1, 2024 through May 31, 2025. The previous reports, which summarize the Division's mental health parity activities from the Act's effective date of May 16, 2019 through May 31, 2024, as well as the statutorily-required December 2022 premium impact report, can be found on the Division's website here.
As required by § 10-16-147, C.R.S., this report discusses the methodology used and rules promulgated to verify health insurance carrier compliance with State and federal mental health parity laws, market conduct examination activities, and educational and corrective actions taken during the preceding twelve (12) months. In addition to these statutory reporting requirements, this report summarizes other Division behavioral health strategies implemented in the last year to increase access to quality, affordable, and culturally-competent care and insurance coverage, while also identifying persistent gaps in care and coverage for consumers across Colorado.

According to the 2023 Colorado Health Access Survey (CHAS), cost of care is the primary reason for delaying care, despite Coloradans having the lowest uninsured rate since 2009. One in five respondents (19.8%) said they did not fill a prescription, get general doctor care, or get specialty care when they needed it due to cost, representing over 1.1 million people. More people than ever measured by the CHAS, one (1) in four (4) Coloradans, reported poor mental health, defined as having eight (8) or more days of poor mental health in the previous month, and more people than ever reported that they could not get the mental health care they needed. The reasons for not getting the care they needed include:

- 57.2% had a hard time getting an appointment;
- 53.9% were concerned about the cost of treatment;
- 46.9% worried health insurance wouldn't cover it;
- 37.6% weren't comfortable talking with a professional about personal problems; and
- 22.7% worried about stigma and what would happen if someone found out about their personal problems.

Further, an April 2024 report, Behavioral Health Parity - Pervasive Disparities in Access to In-Network Care Continue, indicates that Coloradans are twelve (12) times more likely to use an out of network (OON) psychiatrist than an OON medical/surgical specialist physician and 10.6 times more likely to use an OON therapist than a comparable OON physical health provider, like a physician assistant (Appendix B-3), creating a greater financial burden on consumers than if an in-network provider had been used. As detailed in the "Provider Support Resources" section below, the Division has implemented a number of strategies to address the burdens that lead to some providers choosing to provide care out of commercial insurance networks.

Such data illustrates that Coloradans continue to need and seek accessible, affordable, and culturally-competent behavioral health care. While progress has been made to decrease the cost of coverage, increase access to culturally-competent care in-network, improve

behavioral health provider experience with commercial insurance networks, and disseminate consumer educational resources on state and federal coverage requirements, there is more work to do. The Division continues to proactively respond to the immediate and long-term behavioral health needs facing Coloradans, and it is pleased to share this summary of its behavioral health program efforts with the General Assembly.

Background: Mental Health Parity and Addiction Equity Act (MHPAEA)

Federal and Colorado State law requires that health insurance carriers cover services for mental health, behavioral health, and SUD conditions comparable to and no more restrictive to the way they cover other physical health conditions, like diabetes or heart disease. This is called "parity." The core concept of parity is that people seeking mental and behavioral health care should be treated fairly and similarly to people seeking physical health services. Evaluation of parity is complex and involves comparing mental health, behavioral health, and SUD treatment to medical and surgical care across six (6) benefit classifications, which include in-network inpatient care, out-of-network inpatient care, in-network outpatient care, out-of-network outpatient care, emergency care, and prescription drugs.

Parity laws prohibit health insurance plans from being more restrictive in providing mental health, behavioral health, and SUD benefits than they would be for medical and surgical benefits. It is measured using Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs):

- QTLs measure whether numerical values like copayments, coinsurance, outpatient visit limits, inpatient daily limits, deductibles, annual caps on reimbursement, and reimbursement rates are comparable for behavioral health and physical health.
- NQTLs cannot generally be measured numerically, and as a result can be more challenging to measure than QTLs. Examples of NQTLs include, but are not limited to, network credentialing standards, medical necessity criteria, evidentiary standards, pharmacy design, geographic restrictions, self-harm and suicidal exclusions of coverage, utilization management processes, preauthorization requirements, network adequacy standards, standards for denials of care, fail-first and step therapy requirements, provider reimbursement practices, facility type restrictions, network tier design, and likelihood of improvement criteria.

Both federal and Colorado State law provide protections for consumers accessing mental health, behavioral health, and SUD services. The following list of State and federal policies is not exhaustive; rather, it provides context to the pillars of mental health parity enforcement in Colorado and relevant updates since the previous report.

- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): This federal law - also called the Parity Law - requires health insurance coverage for mental health and/or SUD conditions to be comparable to what patients would receive for coverage of medical/surgical services, if they provide mental health and SUD benefits.

  MHPAEA requires insurance companies to administer mental health and SUD benefits comparable to the way they administer medical and surgical benefits, addressing limits on QTL factors such as visits and deductibles, as well as limits or requirements around NQTL issues like prior authorization and network criteria. The final federal regulation implementing MHPAEA went into effect on January 13, 2014.

MHPAEA was amended by the Consolidated Appropriations Act, 2021 (CAA 2021), which furnished the Departments of Health and Human Services, Labor, and Treasury with new enforcement tools by amending MHPAEA to require plans and issuers to provide comparative analyses of their NQTLs to the Departments and authorize the Secretaries of those Departments to make determinations on MHPAEA compliance.

Further, the 2022 MHPAEA Report to Congress highlights the emphasis by the federal government on greater MHPAEA enforcement and discusses the significant resources dedicated to supporting these efforts. While these changes impact compliance requirements nationally, the Colorado state law already required these provisions of carriers.

In July 2023, the United States Departments of the Treasury, Labor, and Health and Human Services (the Departments) issued Technical Release 2023-01P, which set out principles and sought comments regarding new requirements for health plans when they collect and evaluate data for NQTLs related to network composition and MHPAEA compliance. It referenced existing models and methodologies utilized by several states and private organizations, including the National Association of Insurance Commissioners (NAIC) MHPAEA (B) Working Group. The Division continues to research best practice models like these for NQTL review and compliance and assessment.

The Departments promulgated the Final Rules in September 2024, which are further explained later in this report. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes for responding to requests for NQTL comparative analyses required under MHPAEA, as amended by the CAA, 2021. These final rules aim to further MHPAEA's fundamental purpose – to ensure that individuals in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater burdens on access to benefits for those conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or a surgical procedure.

- Patient Protection and Affordable Care Act of 2010 (ACA): In addition to giving people better access to health insurance and health care, the ACA helps to further enforce mental health parity. It requires that individual and small group plans (except grandfathered plans created before the ACA) cover mental health and SUD services as essential health benefits. This includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services, and SUD treatment. It also requires that plans cover pre-existing mental and behavioral health conditions, like depression and anxiety, while eliminating annual and lifetime spending limits.

  The ACA and MHPAEA work together to require coverage for mental health, behavioral health, and SUD treatment.

- Behavioral Health Care Coverage Modernization Act (2019): In regards to the private insurance market, the Colorado Behavioral Health Care Coverage Modernization Act specifies compliance with MHPAEA and mandatory coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and SUD. It includes mental health parity requirements related to QTLs and NQTLs, network adequacy and provider reimbursement standards, SUD and behavioral health screening standards, pharmacy benefit design, an updated statutory definition of "behavioral, mental

health, and substance use disorder," information on appeal processes for denials, and carrier reporting requirements.

- Colorado Insurance Regulation 4-2-64 - Concerning Mental Health Parity in Health Benefit Plans: This regulation provides requirements that carriers must follow to comply with the mental health parity laws, as well as the specific formats in which carriers must submit parity data to the Division. They include:
    - Minimum coverage requirements for mental health, behavioral health, and SUD treatment;
    - Expectations of the financial requirements and design of health benefit plans necessary to be compliant with parity requirements;
    - The format to submit carrier-specific information on QTLs, such as visit limits, deductibles, and dollar amounts for co-pays and co-insurance, and NQTLs, including medical necessity criteria, step therapy and prior authorization requirements, formulary design for prescription drugs, and failure to improve criteria; and
    - Requirements of a written notice of, and the reason for, denials of benefits for behavioral health, mental health, or SUD services and the provision of resources to consumers to assist with a denial.

  This rule and related instructions apply to all health benefit plans that are regulated by the Division and that are marketed and issued in the individual, small group and large group markets in Colorado, including non-grandfathered health benefit plans, short-term limited duration health insurance policies, and student health insurance coverage. It does not apply to grandfathered health benefit plans or to limited benefit plans, as defined in § 10-16-102(32)(b), C.R.S., and some exclusions for coverage of specific mandated benefits as found at § 10-16-104(1.4), C.R.S. Carriers submit data collection templates to the Division annually, found here.

  The Division hosted a carrier-specific Town Hall meeting March 5, 2024, to seek feedback on reporting processes, procedures, and understanding of requirements. Information received from the Town Hall was documented and was used to determine regulation revisions, in addition to the standard regulatory stakeholder process. A recording of the Town Hall is publicly available on the Division's website. In December 2024, taking into account the feedback provided, the Division posted a notice of adoption for the amended regulation 4-2-64 with an effective date of January 30, 2025. The purpose of amending this regulation was to update, streamline, and clarify the reporting requirements and templates.

- Amended Regulation 4-2-53 Network Adequacy Standards and Reporting Requirements for ACA-Compliant Health Benefit Plans went into effect on June 30, 2023. This amended regulation further clarifies standards and reporting requirements for behavioral health providers that had not been specifically delineated prior to the revision, Licensed Addiction Counselors (LACs), Outpatient Clinical Behavioral Health providers (licensed, accredited, or certified professionals), Inpatient and Residential Behavioral Health Facility Services, Licensed Marriage and Family Counselors, Licensed Professional Counselors, and Opioid Treatment Programs (OTPs).
- Amended Regulation 4-2-54 Network Access Plan Standards and Reporting Requirements for ACA-Compliance Health Benefit Plans went into effect on June 30, 2023, and requires reporting on the carrier's ability to comply with distance standards for the provider types listed above and included in amended regulation 4-2-53,

- Amended Regulation 4-2-55 Standards and Reporting Requirements for ACA-Compliant Health Benefit Plan Provider Directories went into effect on July 15, 2023, and requires the provider types referenced in the amended regulation 4-2-53, above, to be included in provider directories.
- Colorado Insurance Regulation 4-2-75 Concerning Requirements for Reporting Medication-Assisted Treatment Coverage creates reporting and data collection requirements regarding access to medication-assisted treatment (MAT) for SUD and opioid use disorder (OUD). Carriers report to the Division annually information that includes, but is not limited to, the number of providers per county, prescriptions filled, utilization management protocols, and carrier efforts to ensure access to MAT for SUD as required by § 10-16-710(1)-(2), C.R.S.

  The Division reviews carrier compliance with the below requirements for MAT for SUDs, which includes alcohol use disorder (AUD), tobacco use disorder (TUD), Opioid Use Disorder (OUD), and opioid overdose reversal agents. It reviews the following requirements as part of the rates and forms filings and through retrospective inquiries:

  MAT Tier Placement: § 10-16-148(1)(c), C.R.S., requires that carriers place at least one (1) covered prescription medication approved by the Food and Drug Administration (FDA) for the treatment of SUDs on the lowest tier of the drug formulary developed and maintained by the carrier.

  Utilization Management Requirements: § 10-16-148(1)(a)-(b) C.R.S. requires that carriers may not impose prior authorization or step therapy requirements for prescription medication approved by the FDA for the treatment of SUDs.

  Discriminatory Formulary Design: The Division works to ensure formularies are not designed in potentially discriminatory ways, including but not limited to, excluding coverage for a medication entirely or by condition or placing many or most medications for a particular condition on high-cost tiers in order to manage the utilization of medications for conditions. Such formulary designs can negatively restrict or exclude a consumer's access to care.

- The 2023 Essential Health Benefit (EHB) plan sets standards for EHBs within Colorado that went into effect January 1, 2023, for individual and small group plans. The plan includes the following behavioral health coverage changes: comprehensive gender-affirming care to treat gender dysphoria, fifteen (15) ALTO medications and six (6) acupuncture visits per year for pain management and to mitigate OUD, and an Annual Mental Wellness Exam. Annual review and enforcement processes were updated last year to systematically ensure coverage as required by the Benchmark Plan.

In addition, the Colorado Legislature passed two bills, HB 23-1130 Drug Coverage For Serious Mental Illness and SB23-176 Protections For People With An Eating Disorder, during the 2023 legislative session that pertain to commercial behavioral health coverage and required the Division to promulgate rules.

- New Regulation 4-2-100 implements sections 10-16-145(1)(f.5) and 10-16-145(4.5), C.R.S enacted in HB23-1130 and establishes the requirements, process, and form to be utilized by health benefit plans for step therapy utilization and exceptions for enrollees with serious mental illnesses. This regulation became effective on January 1, 2025.
- Amended Regulation 4-2-64 includes the requirements set out in SB23-176.

At the beginning of 2025, the Colorado Legislature passed two bills that further addressed Behavioral Health coverage requirements and accessibility:

- HB25-1002 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 also specifies criteria to be used for utilization review, service intensity, the level of care for covered persons, and provider reimbursement.
- HB25-1309, codifies gender-affirming health care as a medically necessary treatment and prohibits health insurance plans from denying or limiting such care when prescribed by a provider. It also exempts testosterone prescriptions from prescription drug monitoring and restricts access to archived records. This bill aligns and supports ongoing efforts by the Division to ensure coverage for gender-affirming care as is currently required.

Division Strategies to Ensure High Quality and Affordable Behavioral Health Coverage

Colorado Option

The Colorado Option was enacted through HB21-1232, which was signed into law by Governor Polis in June 2021. Starting in 2023, the Colorado Option became available to all Coloradans who buy their health insurance on the individual market (i.e., not from an employer) and to small employers with less than 100 employees. Colorado Option plans are required to reduce health care costs for individuals, families, and small businesses.

As part of the Colorado Option, the Division has created Standardized Plans ("Colorado Option plans") which allow consumers and businesses to easily compare plans and choose the plan that is right for them. These plans cover all essential health benefits, including mental health, behavioral health, and SUD, as required by the Affordable Care Act. They also provide many high value services without consumer cost-sharing and are designed to reduce racial health disparities and improve health equity. The Colorado Option plans include no cost-share for mental health, behavioral health, and SUD care office visits.

During the Plan Year 2025 Open Enrollment, between November 1, 2024 and January 15, 2025, 132,791 people enrolled in a Colorado Option plan, representing 47% of all selections for 2025 on Connect for Health Colorado.

On January 15, 2025, Brown University's School of Public Health released research estimating that the addition of Colorado Option plans to the individual market showed premiums of over $100 less than corresponding premiums in comparison states and these reductions applied to all individual market plans, including non-option plans. The researchers note that the premium and health care cost reductions from the Colorado Option set Colorado apart when compared to other states, where health care costs and premiums have increased by nearly 10% annually.

Colorado Insurance Regulation 4-2-64 Concerning Mental Health Parity in Health Benefit Plans

Prior to the passage of the Behavioral Health Care Coverage Modernization Act, carriers were required to certify compliance with federal mental health parity laws and regulations in an

annually-submitted attestation form. The Act required carriers to submit to the Division mental health parity data on an annual basis as required by Colorado Insurance Regulation 4-2-64, previously described in the section titled “Background: Mental Health Parity and Addiction Equity Act (MHPAEA).” The Division staff provide written and verbal procedural guidance and annual technical assistance webinars to carriers for accurate and timely submission. All filings, with the exception of appendices deemed confidential, are public via the System for Electronic Rates and Forms Filing (SERFF). The following illustrates the Division’s activities to enforce MHPAEA compliance through its Rates and Forms activities:

QTL Enforcement

The Division’s MHPAEA enforcement strategy includes mechanisms to ensure consumers are not overpaying for behavioral health services. Under MHPAEA, if a plan or issuer that offers medical/surgical and mental health and SUD benefits impose “financial requirements,” such as deductibles, copayments, coinsurance and out of pocket limitations, the financial requirements applicable to mental health and SUD benefits can be no more restrictive than the “predominant” financial requirements applied to “substantially all” medical/surgical benefits. This ensures that cost-sharing for behavioral health is not more expensive than cost-sharing for physical health and that consumers don’t pay more for behavioral health care than allowed by state and federal parity requirements.

The Division Rates and Forms and Actuarial Sections strategically select plans for analysis that together cover at least 85% of the carriers’ populations in each county. They analyze enrollment data submitted in the most recent annual rate filings and sort plans by rating areas, county, and enrollment for each carrier. If a carrier has one plan in the county, the plan is selected for the financial requirement analysis. Otherwise, plans are chosen until the 85% population threshold is reached. Additionally, all Colorado Option plans are reviewed. This selection approach ensures that the financial requirement analysis on cost-sharing and deductibles has the greatest geographic and consumer impact. Carrier rates are not approved until all financial requirements identified and reviewed are compliant.

Each plan and benefit classification undergoes the “substantially-all” and “predominant level testing” annually to ensure mental health, behavioral health, and SUD treatment cost-sharing is no more restrictive than physical health cost-sharing, and the Division provides verbal and written training and technical assistance to carriers to ensure compliance. Carriers should be submitting “passing” cost-sharing structures, although many carriers continue to require multiple resubmissions to get into compliance with the financial requirement testing.

During this report’s timeframe (PY 2025), the Division tested 505 total plans for financial requirement compliance. This total includes Filing Year (FY) 2024 large group (100 or more employees) and student health plans (offered through a higher education institution) and PY 2024 individual (individual people and households) and small group (less than 100 employees) plans.

Carriers have continued to make progress in self-driven compliance with financial requirements since the Division’s increased enforcement in 2019. In the table below, a general decrease in plan failures can be seen year over year for all markets.

Reporting Period	Plans Tested	Plans Failed	Percent Failed
2021-2022 (PY2022/FY2021)	425	38	9%
2022-2023 (PY2023/FY2022)	987	169	17.1%
2023-2024 (PY2024/FY2023)	785	73	9.3%
2024-2025 (PY2025/FY2024)	733	28	3.8%

NQTL Enforcement: In addition to the QTL and financial requirement analyses conducted, the Division reviews the following NQTL topics annually:

- Policies and procedures related to mental health, behavioral health, SUD, pharmacy services, and medical/surgical care;
- Comparative review of claims data which includes assessing out-of-network utilization and claim denials;
- Network adequacy: Provider credentialing and network admission;
- Network development;
- Comparative analyses assessment;
- Medical management and utilization management criteria;
- American Society of Addiction Medicine Criteria Utilization; and
- Provider reimbursement rates and determination methodology.

Annual ACA Rate and Form Review Process

The Division reviews and assesses annually the insurance products to be sold on the individual and small group markets for federal and state compliance requirements, including MHPAEA. Prior to annual submission by the carriers, the Division creates a comprehensive set of instructions for carriers to submit information about coverage, exclusions, cost, and other ACA requirements.

Plan Year 2024: The Division revised carriers' submission instructions to ensure carriers were providing clear and transparent explanation of benefits and coverage requirements in its consumer-facing policy documents related to various behavioral health conditions, statutory changes, and consumer complaints. Between June and September 2023, the Division reviewed 45 plans for ten (10) carriers on the PY2024 individual and small group markets to ensure behavioral health coverage-specific compliance with the 2023 EHB plan requirements, Amended Regulation 4-2-58 Non-Discriminatory Cost-Sharing and Tiering Requirements for Prescription Drugs, 4-2-62 Concerning Prohibitions on Discrimination Based Upon Sexual Orientation or Gender Identity, Colorado Insurance Regulation 4-6-64, and Colorado Insurance Regulation 4-2-75. All plans reviewed received objections and required revisions in order to meet the Division's communication requirements to ensure coverage transparency and mitigate consumer confusion or harm. It reviewed carriers' forms and policy documents for topics including the following:

Gender Dysphoria: Coverage for the treatment of gender dysphoria, which is the clinical diagnosis of "incongruence" between assigned gender and experienced gender, is defined in the Diagnostic and Statistical Manual of

Mental Disorders (DSM), thus included in the Division's behavioral health program.

In order to improve consumers' coverage transparency and insurance literacy, the Division revised the annual binder and form review process in PY 2024 to include more clearly stated coverage for gender dysphoria to address consumer confusion with specific benefit coverage. It required carriers to clearly list each covered hormone therapy medication and gender dysphoria treatment procedure, including office visits, laboratory testing, and other ancillary services. While carriers were required to adhere to such requirements previously, the Division had received a number of complaints from consumers, providers, and consumer groups regarding the lack of transparency on coverage for specific services and medications.

Prescription Medications: The Division reviewed carrier submissions to ensure required coverage of MAT for SUD and alternatives to opioids (ALTOs).

Autism Spectrum Disorder (ASD) Treatment and Services: The Division reviewed all carrier form submissions to ensure there are no visit limits placed on occupational and rehabilitation services to treat autism spectrum disorder (ASD).

Plan Year 2025: In March 2024, the Division revised the form instructions to ensure carriers were providing clear and transparent explanation of benefits and coverage requirements in its consumer-facing policy documents, related to the following, in addition to previously included topics. The review occurred between June and September 2024.

Medical Necessity Criteria for Eating Disorder Treatment: The Division required carriers to include information in its consumer-facing policy documents regarding medical necessity criteria for treatment associated 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 defined in the most recent edition of the DSM. During the annual review process, the Division reviewed and confirmed language that carriers are not utilizing body mass index, ideal body weight, 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, as specified in § 10-16-166, C.R.S.

MAT Prescription Drug Coverage: The Division required carriers to include in their consumer-facing policy documents specific language regarding coverage of:

- Opioid Treatment Program (OTP) services, including methadone administration and maintenance for the treatment of opioid use disorder (OUD)
- FDA-approved prescription drugs listed on formulary for the treatment of SUDs without prior authorization or step therapy
- At least one (1) FDA approved medication for the treatment of each SUD, which includes alcohol use disorder (AUD), nicotine dependence,

OUD, and opioid overdose, is available on the lowest tier of the formulary as specified in § 10-16-148(1)(a)-(c), C.R.S

ASD Treatment Limitations: The Division required carriers to state in forms that visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are medically necessary to treat ASD.

Plan Year 2026: In March 2025, the Division again revised the form instructions to ensure clear and transparent explanation of benefits and coverage requirements in its consumer-facing policy documents, related to the following, in addition to previously included topics.

Substance use disorders - court-ordered treatment coverage: The Division required carriers to include information in its consumer-facing policy documents regarding coverage for treatment of a substance use disorder regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice or legal system (if the Carrier provides coverage for treatment of a substance use disorder).

Market Regulation and Conduct Activities

The Division performs market conduct examinations and actions in accordance with Colorado statutes and regulations using guidance from the NAIC Market Regulation Handbook. These examinations review the "in-practice" aspects of systemic coverage compliance, meaning the ways in which Coloradans are able to access coverage in reality, in addition to "in-policy" coverage compliance, meaning the ways in which Coloradans are supposed to be able to access coverage based on written policies and procedures.

Market Conduct Actions**:** The Division has four market conduct examinations underway.

Consumer Complaints and Public Education Resources

The Consumer Services Section continues to receive and intervene on complaints from both consumers and providers on issues related to insurance coverage for mental health, behavioral health, and SUD. The number of consumer-specific complaints received since the last report are listed below.

Behavioral Health Consumer Complaints
June (previous year) through May (following year), Annually

Reporting Years	Number of Consumer Complaints
2020 - 2021	**18**
2021 - 2022	**28**
2022 - 2023	**28**
2023 - 2024	**46**
2024 - 2025	**95**

Complaint topics pertain to a variety of issues, but most consistently include the following:

- Communication by carriers, including clarity of coverage;
- Network inadequacy;
- Claims processes;
- Provider directory accuracy;
- Denial of benefits coverage; and
- Discrimination.

Consumer Education Resources

The Division updated various behavioral health insurance literacy tools in 2024 and re-shared them with the public during Mental Health Awareness Month in May 2025. The resources, which include information on how to find an in-network provider using one's commercial insurance, can be found on the Division's Mental and Behavioral Health resource page. The resource page was also updated to include new educational resources to explain to consumers how to understand one's mental health benefits, including cost, and how to use one's insurance to find a behavioral health provider.

- Understanding Your Mental Health Benefits
- How to Use Your Insurance to Find a Mental Health Provider

In 2024, the Division updated and released the third Gender-Affirming Care Coverage Guide, which displays a list of gender-affirming services and how they are covered by each insurance company offering individual and small group plans. Please note that it is not an exhaustive list of all gender-affirming care procedures, rather a list of many common services to treat gender dysphoria. It also does not include the different processes, like prior authorization or letters from a provider, that may be required by an insurance company in order to show that it is medically necessary to receive a service or medication. When pursuing a gender-affirming care treatment plan, it is important to inquire with the insurance company in writing to understand the scope and specificity of procedures, medications, and other resources that may be covered or offered. In November 2024, a consumer advisory was released with this information. Although HIV prevention and treatment is not directly a behavioral health service, there are several connections to HIV transmission in people who use injection drugs, use other substances, or are transgender women or men. The Division updated and released an HIV Prevention and Treatment Prescription Drug Coverage Guide to summarize HIV prevention and treatment medications approved by the FDA and published in the US Department of Health and Human Services (HHS) and HIV.gov Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. It lists medications individually by treatment category, as well as by the most commonly prescribed medications by providers for consumers, as specified by the FDA. This resource does not offer clinical advice on medication regimens, rather lists coverage information in this manner for ease of consumer use.

Provider Support Resources

The provider experience with commercial insurance is integral to ensuring that consumers have access to in-network mental health, behavioral health, and SUD providers. The April 2024 Behavioral Health Parity - Pervasive Disparities in Access to In-Network Care Continue

report reviewed in-network provider reimbursement relative to Medicare reimbursement rates across all codes and all specialties. In Colorado, reimbursement rates for in-network office visits for calendar year 2021 were an average of 30% higher for all medical/surgical providers compared to all behavioral health providers (Appendix B-17). Reimbursement was also reviewed at the 50th, 75th and 95th quartiles. At the 95th quartile, the disparity between all medical/surgical providers and all behavioral health providers widened significantly with all medical/surgical providers reimbursed 89% higher than all behavioral health providers (Appendix C-24), which may indicate carrier practices on rate negotiation in high need or provider shortage areas.

Providers continue to report issues with commercial network admission and retention. The Division continues to identify and explore barriers that dissuade or impede a provider from participating in commercial networks in Colorado. Provider-identified issues that negatively impact the ability to participate in commercial insurance included, but are not limited to, the following:

Network admission: Credentialing policies, processes, and timeline (including pre-license, provisional, and delegated applicants), contract negotiation, and reimbursement rates.

Network retention: Increases to and parity of reimbursement rates, post-payment audit issues, and claims handling.

The following information outlines resources and processes to ensure carrier compliance that impact behavioral health providers.

Behavioral Health Provider Resource Page

In 2023, the Division created and published the Commercial Insurance Resources for Behavioral Health Providers in Colorado webpage. This page includes information and frequently asked questions (FAQs) for behavioral health providers that pertain to commercial coverage of behavioral health care and requirements for provider-carrier interactions, including:

- Standards, timelines, and interest accrual claim payments requirements
- Provider-carrier contract requirements
- Carrier requirements on network admission
- Utilization management requirement processes
- Appeal and alternative dispute resolution processes

The Division continues to update, receive, review, and offer support for provider complaints received.

Behavioral Health Provider Complaint Submission Platform and Process

Complaints may be submitted to the Division through the provider complaint form, through the consumer services complaint portal, or individually to a Division staff person. The Division created an email address to receive behavioral health provider complaints: dora_bh_provider_issues@state.co.us. The Behavioral Health Provider Complaint Form can be found on the Behavioral Health provider resource webpage listed above.

Behavioral Health Provider Complaint Form Response Summary

At the time of writing, since the Division began tracking complaints on January 1, 2023, it has received 143 complaints from providers throughout the state.

Topics include:

- Timely claims and interest accrual payments;
- Network admission;
- Reimbursement rate determination; and
- Network directory accuracy.

Primary Care and Behavioral Health Integration

Each year, the Primary Care Payment Reform Collaborative (the Collaborative) publishes a report of primary care payment reform recommendations, which is available to the public. Since its creation in July 2019, the Collaborative has released six annual reports, as well as a set of recommendations around the use of telehealth to support primary care delivery. In its February 2024 report, the Collaborative chose to focus on a single topic — the integration of behavioral health into primary care — and issued four recommendations for health care payers and providers aimed at improving payment for the delivery of integrated, team-based care delivery in primary care settings, as well as supporting primary care providers in offering MAT services.

To further advance integrated care delivery, the Division collaborated with the Department of Health Care Policy and Financing (HCPF) and the Behavioral Health Administration (BHA) to develop the HB22-1302 Integrated Care Legislative Report, which was submitted to the legislature on January 13, 2025 and includes recommendations on best practices for sustaining integrated care models. In preparing the report, the Division participated in multiple stakeholder discussions with HCPF, the BHA, integrated care practices, Regional Accountable Entities (RAEs), and private payers. Multi-payer alignment to support integrated care delivery was identified as a key need, and a goal that the Division, both through the Collaborative and its other primary care work, is continuing to pursue.

Children and Youth Behavioral Health Implementation Plan

The Division worked with the Behavioral Health Administration and other Colorado State agencies to review and compile its existing efforts to serve and improve the behavioral health needs of children and youth in Colorado. Together, it created the Children and Youth Behavioral Health Implementation Plan. With almost 100 action items, the plan lists opportunities to:

- promote the well-being of children and youth;
- establish a comprehensive continuum of behavioral health services;
- create the foundation for a system of care framework unique to Colorado;
- reduce barriers to access and affordability of care;
- support a competent and adequate workforce; and
- have accountability and oversight to ensure a quality behavioral health system.

The Division continues to participate in the monthly CYBH Plan Steering Committee where plan actions are discussed, developed, and implemented.

NAIC MHPAEA (B) Working Group

The Division works with other states and the Departments to create, coordinate, and refine best practices in MHPAEA implementation and enforcement. For example, the Division utilized best practices learned from the workgroup to update the data collection templates for financial requirements, QTLs, comparative analyses, and other NQTLs to collect information from carriers as outlined in Colorado Insurance Regulation 4-2-64. The workgroup also monitors, reports, and analyzes developments related to MHPAEA and makes recommendations regarding NAIC strategy and policy to ensure states, like Colorado, stay on the forefront of mental health parity implementation and enforcement.

Conclusion

While much progress has been made to reform Colorado's behavioral health system and work towards parity in the commercial market, the Division knows there is more work to be done. Consumers throughout the state must have access to adequate mental health, SUD, and overall behavioral health treatment providers in-network, yet some continue to struggle with finding a provider that can meet their needs. Providers report issues getting credentialed in-network in a reasonable amount of time, significant administrative burden when in the network, and challenges with both reimbursement rates and delays in reimbursements. Issues like these disincentivize providers from participating in commercial insurance networks, further limiting access to necessary care for consumers throughout the state.

The Division continues to review and enforce state requirements on behavioral health coverage, using various tools to ensure quality, affordable, and accessible coverage of behavioral health care. These include, but are not limited to market conduct activities, regulatory oversight, data collection and analysis, and insurance literacy and educational resources.

The activities highlighted in this report illustrate some of the momentum that continues to build in the state. The Division looks forward to continuing work with the Legislature, state agencies, health insurance carriers, service organizations, health care providers, and communities in future efforts to ensure that the behavioral health system works for every Coloradan.