

HB19-1269: MENTAL HEALTH PARITY INSURANCE MEDICAID

Concerning measures to improve behavioral health care coverage practices.

Details

Bill Sponsors:	House – <i>Cutter (D) and Sullivan (D)</i> , Kipp (D), Michaelson Jenet (D), Mullica (D) Senate – <i>Ginal (D)</i>
Committee:	House Public Health Care & Human Services House Appropriations
Bill History:	3/25/2019 – Introduced 4/5/2019 – Hearing In House Public Health Care & Human Services
Next Action:	Hearing in House Appropriations
Fiscal Note:	<u>4/3/2019 Version</u>

Bill Summary

The bill enacts the “Behavioral Health Care Coverage Modernization Act” in order to address health coverage parity issues for behavioral health benefits.

The bill requires insurance coverage to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and that coverage for behavioral health disorders include coverage for the prevention, screening, and treatment of those disorders. Further, the bill requires behavioral health services continue while a claim for the services is under review by the insurance carrier. It also requires carriers to comply with treatment limitations specified in federal regulations. The bill alters the definition of behavioral, mental health, and substance use disorder to include the latest expert-developed references. The bill continues to update the required coverage for alcohol use and behavioral health screenings to reflect current recommendations of the U.S. Preventive Services Task Force. The bill requires the Commissioner of Insurance to not approve a carrier’s requested rate increase if it fails to demonstrate compliance with MHPAEA. Carriers must submit an annual parity report to the Commissioner of Insurance. Starting on January 1, 2020 carriers providing prescription drug benefits must provide certain coverage for Food and Drug Administration (FDA) approved medication for treating substance use disorders.

The bill requires the Colorado Department of Health Care Policy and Financing (HCPF) to ensure that the Medicaid program complies with MHPAEA. The bill requires contracted managed care entities participating in the Medicaid program to provide an adequate network of providers. Managed care entities are prohibited from denying payment for medically necessary and covered treatment on the basis that the covered diagnosis is not the primary diagnosis. HCPF must make annual network adequacy plans public and examine complaints of MHPAEA violations. HCPF must submit an annual parity report to the General Assembly. Starting on January 1, 2020 managed care entities providing prescription drug benefits must provide certain coverage for FDA-approved medication for treating substance use disorders.

Issue Summary

Federal Law: Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Mental Health Parity Act (MHPA) was passed in 1996. The MHPA applied to large employer-sponsored health plans, both fully-insured and self-funded, and solely prohibited the plans from imposing higher annual

or lifetime financial limits on mental health benefits than for medical or surgical benefits.¹ While the MHPA was a first step, there were many holes, thus the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008. The MHPAEA continued to apply to both fully-insured and self-funded large group plans (self-funded large groups may opt-out); but, the MHPAEA expanded to include the treatment of substance use disorders (SUDs) while prohibiting differences in treatment limits, cost sharing, and network coverage. With the passage of the Affordable Care Act (ACA), MHPAEA also applied to plans in the individual market as well as the individual and small group plans offered on the marketplace. The ACA mandates coverage of mental health and SUD treatment through the essential health benefits. Thus, in order to satisfy the essential health benefit requirement, insurers must comply with MHPAEA.

After the passage of MHPAEA, regulations were finalized in November 2013² that required both quantitative treatment limitations (QTLs) and nonquantitative treatment limits (NQTLs) to be comparable for behavioral health and medical/surgical benefits.³ The following chart demonstrates some of the QTLs and NQTLs.⁴

Quantitative Treatment Limitations & Nonquantitative Treatment Limits		
Treatment Limitations	Health Plan Components	Examples
Quantitative Treatment Limitations (QTLs)	Financial Requirements	Deductibles, co-pays, out-of-pocket limits, annual or lifetime limits on behavioral health care
	Treatment/Service Limitations	Number of visits or hospital days
	Out-of-Network Benefits	Behavioral health providers that are outside of a plan's network
Nonquantitative Treatment Limitations (NQTLs)	Prior Authorization	Requirements for an insurer to review and approve behavioral health services to determine medical necessity
	Medical Necessity Requirements	Denials for treatment based on medical necessity
	"Fail First" Medication Requirements	Requirements to try medications other than the preferred medication from a behavioral health provider
	Provider Networks	Availability of providers

MHPAEA does not apply to following types of plans: Medicare, Medicaid fee-for-service plans, Tricare/Department of Defense plans, Federal Employees Health Benefits Plans, individual and group plans that were "grandfathered" in as they were created before the ACA, and local and state government plans can apply for an exemption.⁵

¹ Health Affairs (Apr. 3, 2014). *Mental Health Parity*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20140403.871424/full/>

² 45 CFR § 146.136. Retrieved from <https://www.law.cornell.edu/cfr/text/45/146.13>

³ Peterson, E. & Busch, S. (Apr. 2018). Achieving Mental Health and Substance Use Disorder Treatment Parity: A Quarter Century of Policy Making and Research. *Annual Review of Public Health* 32. Retrieved from <https://www.annualreviews.org/doi/10.1146/annurev-publhealth-040617-013603>

⁴ Chart derived from one created by the Hogg Foundation for Mental Health. More information at: <http://hogg.utexas.edu/wp-content/uploads/2017/12/Mental-Health-Parity-Fact-Sheet.pdf>

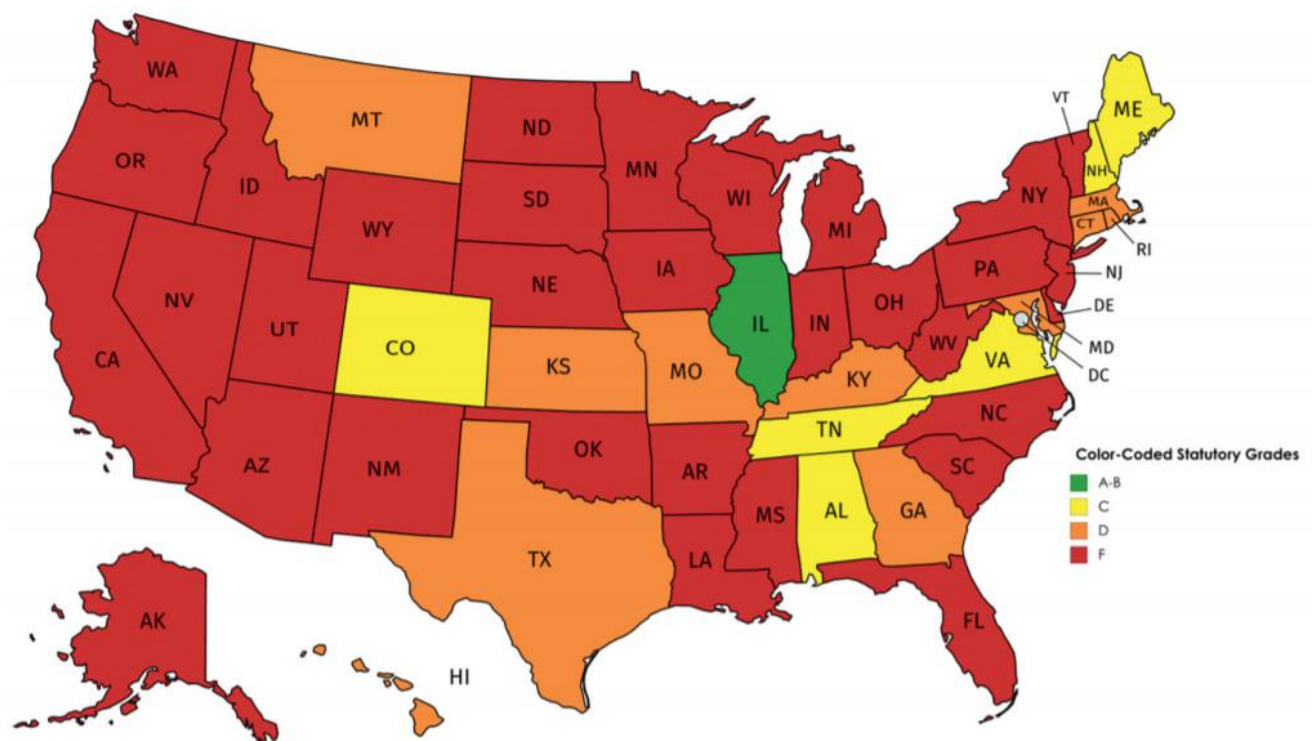
⁵ Douglas, M. et al. (2018). What is Mental Health Parity? A Consumer Guide to the Evaluating State Mental Health and Addiction Parity Statutes Report. *The Kennedy Forum*. Retrieved from https://chp-wp-uploads.s3.amazonaws.com/www.paritytrack.org/uploads/2018/09/KF-Evaluating-State-Mental-Health-Consumer-Brief-0918_web.pdf; Mental Health America (n.d.) *Issue Brief: Parity*. Retrieved from <http://www.mentalhealthamerica.net/issues/issue-brief-parity>

The federal Employee Benefits Security Administration (EBSA) enforces Title I of the Employee Retirement Income Security Act of 1974 (ERISA), which governs 2.2 million private employment-based group health plans (both fully-insured and self-funded large group plans), which cover over 130 million individuals. For fiscal year 2017, of the 187 investigations where MHPAEA applied, EBSA cited 92 violations. Almost half (48.91 percent) were violations of nonquantitative treatment limits and more than a quarter (28.26 percent) were violations of financial limits and quantitative treatment limits.⁶

State Parity

There is wide variability among the states in regards to state-level parity laws as MHPAEA does not preempt state parity laws that are more stringent.⁷ The following map from the Kennedy Forum demonstrates the grades that states were given in regards to their parity language in state statute.⁸

Figure 1: Map of the United States, Color Coded by Statutory Grades



The most common gaps in parity laws in state statutes are how mental health and SUDs are defined and covered as well as how compliance is monitored and enforced. The notable exception on the above map is Illinois, which scored a perfect score on the report's scoring index. The strengths of Illinois' parity statute includes the fact that the definition of mental health and SUDs is tied to the latest expert-developed references. Further, it requires the state's Department of Insurance to proactively enforce parity and collect reports of compliance for health plan approval. The law goes further by requiring state and local government

⁶ US. Employee Benefits Security Administration (n.d.) *Fact Sheet: FY2017 MHPAEA Enforcement*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf>

⁷ Health Affairs (Apr. 3, 2014). *Mental Health Parity*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20140403.871424/full/>

⁸ Douglas, M. et al. (2018). What is Mental Health Parity? A Consumer Guide to the Evaluating State Mental Health and Addiction Parity Statutes Report. *The Kennedy Forum*. Retrieved from https://chp-wp-uploads.s3.amazonaws.com/www.paritytrack.org/uploads/2018/09/KF-Evaluating-State-Mental-Health-Consumer-Brief-0918_web.pdf

employee health plans to comply with state parity law, even though those entities can “opt-out” under MHPAEA.

Parity in Colorado

Colorado received a “C” grade in regards to the state’s statutes for parity.⁹ It is unknown how many people in Colorado do not have behavioral health coverage equal to that of their physical coverage.¹⁰ The below figure from the Colorado Health Institute indicates that more than 2 million Coloradans are in health plans that can opt out of or do not have to comply with parity requirements . Also of note, but not included in the chart, is that approximately 350,000 Coloradans are uninsured.

Figure 2. Parity Requirements for Mental Health and Substance Use by Insurance Plan

Insurance Plan	Required to Provide Behavioral Health Services	Parity Laws Apply	Coloradans Included
Medicaid/CHP+	Yes	Yes	1,143,000
Individual	Yes	Yes	437,000
Small Group Plans	Yes	Yes	383,000
Fully Insured Large Group Plans	Yes	Yes	992,000
Self-Funded Large Group Plans	No	Can Opt Out	1,300,000
Medicare	No	No	776,000

Source: Colorado Department of Regulatory Agencies. (2018).⁴

In 2018, the General Assembly created the Office of the Ombudsman for Behavioral Health Access to Care.¹¹ The office is intended to assist residents with coverage and access issues relating to behavioral health, including parity.

This Legislation

Mandatory Coverage Provisions for Mental Health and Substance Use Disorders

The bill amends existing statute to require every health benefit plan under the purview of the Division of Insurance (DOI) (in general, this includes individual plans, small group plans, and some aspects of fully-insured large group plans,) to provide coverage for the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders that is not less extensive than the coverage provided for any physical illness and the coverage must comply with the MHPAEA. If there is concurrent review for a claim for services for the prevention of, screening for, and treatment of behavioral, mental health, and substance use disorders, the service continues to be a covered service until the carrier notifies the person regarding the determination of the claim.

A carrier providing a health plan is to comply with the nonquantitative treatment limitation (NQTL) requirements, specified in the regulations¹² following the passage of MHPAEA, which includes any limitations that are not expressed numerically but otherwise limit the scope or duration of treatment benefits. This includes for in-network and out-of-network inpatient and outpatient benefits, emergency care, prescription

⁹ Parity Tracker (n.d.) *State Report Card: Colorado*. Retrieved from https://chp-wp-uploads.s3.amazonaws.com/www.paritytrack.org/uploads/2018/09/StateReportCard_06_CO.pdf

¹⁰ Colorado Health Institute (March 2019). *Parity Remains a Work in Progress for Colorado*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/SUD.pdf

¹¹ HB18-1357. More information at: <http://leg.colorado.gov/bills/HB18-1357>

¹² 45 CFR 146.136 (c)(4)(i)

drugs, the methods for networking with providers, and the response to the lack of timely access to care within the network. The carrier must comply with the financial requirements and quantitative treatment limitations (QTLs) specified within federal regulations.¹³ The carrier shall not apply any NQTLs to behavioral, mental health, or substance use disorder benefits that are not applied to medical/surgical benefits that are in the same benefit classification. Carriers are to establish procedures to authorize treatment with an out-of-network provider if a covered service is not available within established times and distances and within a reasonable period. This treatment is to have the same cost sharing requirements that apply for an in-network provider and at no greater cost to the person than if the service was obtained from an in-network provider. Finally, the carrier must reimburse out-of-network providers for treatment or services that are required to be covered using the same methodology the carrier uses to reimburse out-of-network providers for medical services, if a covered person obtains a covered service from an out-of-network provider because the service is not available within established time and distance standards. Upon request, evidence of the methodology is to be provided to the provider or covered person. The Commissioner is directed to adopt rules to establish reasonable time periods for visits with a behavioral health provider after an initial visit with a provider.

The bill removes the definitions of “biologically based mental health disorder” and “behavioral, mental health, or substance use.” The bill establishes the definition for “behavioral, mental health, and substance use disorder” as a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of the International Statistical Classification of Diseases and Related Health Problems¹⁴ (ICD), the Diagnostic Statistical Manual of Mental Disorders¹⁵ (DSM), and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood¹⁶ (DC). This includes autism spectrum disorders.¹⁷

Preventive Health Services Coverage

The bill updates the required coverage related to alcohol use and behavioral health screenings to reflect A or B recommendations of the United States Preventive Services Task Force (USPSTF). This includes unhealthy alcohol use screening for adults, depression screening for adolescents and adults, and perinatal maternal counseling for those at-risk. These services can be provided by a primary care provider, behavioral health provider¹⁸, or mental health professional¹⁹.

Requested Rate Increases

The bill adds failure to demonstrate compliance with the MPPAEA as a reason that the Commissioner of Insurance shall disapprove of a health plan’s requested rate increase. The Commissioner is to adopt rules to establish the process and timeline for the carriers to demonstrate compliance in establishing their rates.

¹³ 45 CFR 146.136 (c)(2) & 45 CFR 146.136 (c)(4)

¹⁴ Prepared by the World Health Organization. Also known as the International Classification of Diseases (ICD), ICD-10 is currently implemented and ICD-11 has been released in 2018 to allow United Nations member states time to prepare for when it goes into effect January 2022. More info at: <https://www.who.int/health-topics/international-classification-of-diseases>

¹⁵ Prepared by the American Psychiatric Association, current manual is the DSM-5. More info at: <https://www.psychiatry.org/psychiatrists/practice/dsm>

¹⁶ Prepared by ZERO TO THREE, current manual is DC: 0-5. More info at: <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>

¹⁷ Currently defined in same section of statute, C.R.S.10-16-104 (1.4)(a)(III)

¹⁸ Defined in C.R.S. 25-1.5-502 (1.3): licensed addiction counselor, certified addiction counselor, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, licensed psychologist, licensed physician assistant with SUDs, advanced practice nurse with specific training in SUDs, pain management, or psychiatry, and a physician with specific board certification/training in addiction medicine, pain management, or psychiatry

¹⁹ Defined in Article 43 of Title 12 in Colorado Revised Statutes: psychologist, licensed social worker, licensed clinical social worker, marriage and family therapists, licensed professional counselors, registered psychotherapists, certified addiction counselors, and licensed addiction counselors

Procedures for Denial of Benefits

Unless a denial is based on nonpayment of premiums, a denial of a request for reimbursement for services to prevent, screen, or treat mental health and SUDs must include the following, in plain language:

- A statement explaining that the covered person is protected under MHPAEA, which provides that limitations placed on access to mental health and SUD benefits cannot be greater than those placed on access to medical and surgical benefits
- A statement providing information about contacting the DOI or Ombudsman for Behavioral Health Access to Care if the person believes that their rights under MHPAEA have been violated
- A statement specifying that the covered person is entitled, upon request to the carrier (free of charge), to a copy of the medical necessity criteria for any mental health or SUD benefit

Prior Authorization

The bill removes a request for prior authorization for medication-assisted treatment (MAT) for Substance Use Disorders (SUD) from the definition for “urgent prior authorization request.”²⁰

Behavioral Health Screenings

A health plan issued or renewed in Colorado on or after January 1, 2020 that provides coverage for an annual physical examination as a preventive service is to also include reimbursement for behavioral health screening using a validated tool, which is no less extensive than the reimbursement for an annual physical.

Parity Reporting

The bill expands the parity reporting required by the Commissioner of Insurance and establishes new reporting by carriers. By June 1, 2020, and by every June 1 thereafter, the Commissioner is to submit a written report to the House Committees on Public Health Care and Human Services and on Health and Insurance as well as the Senate Health and Human Services Committee. The Commissioner is to also provide a presentation of the report to those committees before the upcoming regular legislative session. A health plan is to submit to the Commissioner and make public, by March 1, 2020 and every March 1 thereafter, a report that contains the following information for the previous calendar year:

- Data that demonstrates parity compliance for adverse determinations regarding claims for mental health and SUD services and the total number of adverse determinations for these claims
- Description of the process used to develop or select the medical necessity criteria used in determining mental health and SUD benefits and the criteria used for determining medical/surgical benefits
- Identification of all NQTLs that are applied to benefits for mental health and SUDs as well as medical/surgical
- Results of analyses that demonstrate that the processes, strategies, evidentiary standards, or other factors used for applying medical necessity criteria and each NQTL for mental health and SUD benefits are comparable to and are not applied more stringently than those for medical/surgical benefits within the corresponding classification of benefits

The above analyses must be reported by carriers, the reports at a minimum must:

- Identify the factors used to determine whether a NQTL will apply to a benefit, including [factors that were considered but rejected
- Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on to design NQTL
- Provide the analyses and results of the analyses

²⁰ This part of the definition was recently added in 2018, with the passage of HB18-1007, a bill that came out of the Opioid and Other SUD Study Committee.

- Disclose the specific findings and conclusions reached by the carrier that the results of the analyses demonstrate compliance with state law and the MHPAEA

The Commissioner is to adopt rules that are necessary to implement the reporting requirements, including rules to specify the form and manner of carrier reports. If the Commissioner receives a complaint from the Ombudsman for Behavioral Health Access to Care related to a violation of state law or MHPAEA, they are to examine the complaint and report to the Ombudsman any action taken.

Medication-Assisted Treatment for Substance Use Disorders (SUD)

Beginning January 1, 2020, a carrier that provides prescription drug benefits for SUD treatment shall, for medications that are on the carrier's formulary:

- Not impose prior authorization requirements on any Food and Drug Administration (FDA)-approved medication for SUD treatment
- Not impose any step therapy requirements as a prerequisite to coverage for any FDA-approved medication for SUD treatment
- Place at least one covered FDA-approved medications for SUD treatment on the lowest tier of the drug formulary
- Not exclude coverage for FDA-approved medications for SUD treatment and any associated counseling or wraparound services only on the grounds that the medications and services were court ordered.

Division of Insurance Report: Parity Effects on Premiums

By December 1, 2022, the Commissioner of Insurance is to submit a report to the House Committees on Public Health Care and Human Services and on Health and Insurance as well as the Senate Health and Human Services Committee. The report will detail any effects on premiums that resulted due to the implementation of this bill.

Medicaid Requirements and Compliance

The Department of Health Care Policy and Financing (HCPF) is to ensure that mental health and SUD benefits under Medicaid are no less extensive than benefits for physical illness and are in compliance with MHPAEA, including QTLs and NQTLs. On or after January 1, 2020, if a managed care entity (MCE) denies coverage for a mental health or SUD benefit or service based on diagnosis, HCPF is to reimburse medically necessary services under Medicaid through a procedure that is established by rule. HCPF can utilize multiple payment modalities.

In addition to the network adequacy requirements that are determined by HCPF, the bill requires each MCE to offer an enrollee an initial or subsequent non-urgent care visit for behavioral health within a reasonable time (no more than 7 calendar days) when medically necessary and at appropriate intervals. The diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not prevent a person from receiving a behavioral health service. The bill prohibits an MCE from denying payment for medically necessary and covered treatment for a mental health or SUD diagnosis solely on the condition that the diagnosis is not primary.

HCPF is to make each MCE annual network adequacy plan public. The plan must include actions taken by the MCE to ensure that all necessary and covered primary care, care coordination, and behavioral health services are provided with reasonable promptness. This includes actions to utilize single care agreements with out-of-network providers when necessary and financial incentives to increase provider participation.

HCPF shall examine all complaints from the Ombudsman for Behavioral Health Access to Care related to a violation of state law or MHPAEA, they are to examine the complaint and report to the Ombudsman any action taken.

Medicaid Managed Care Entities Required Statements

Each MCE must include the following statements prominently in the enrollee handbook, on HCPF's website, and the MCE's enrollment website:

- Statement indicating that the MCE is subject to MHPAEA and that a denial, restriction, or withholding of benefits covered under Medicaid could be a potential violation
- Statement directing the enrollee to contact the Ombudsman for Behavioral Health Access to Care if they want further assistance pursuing action regarding potential parity violations. Must include the phone number and web address for the Ombudsman.

Parity Reporting: Medicaid

HCPF is to require each contracted MCE to disclose all necessary information needed by HCPF to submit a parity report by June 1, 2020, and each June 1 thereafter. The report is to be sent to the House Health and Insurance Committee, House Public Health Care and Human Services Committee, and Senate Health and Human Services Committee. The report must be made available to the public. The report must contain the following for the prior calendar year:

- Data that demonstrates parity compliance for adverse claim determinations for behavioral health services and includes the total number of adverse determinations for those claims
- Description of the process used to develop or select the medical necessity criteria used in determining mental health and SUD benefits and the process used for determining medical/surgical benefits
- Identification of all NQTLs that are applied to benefits for mental health and SUDs as well as medical/surgical as well as a statement that the state is complying with federal regulations regarding the use of NQTLs
- Results of analyses that demonstrate that the processes, strategies, evidentiary standards, or other factors used for applying medical necessity criteria and each NQTL for mental health and SUD benefits are comparable to and are not applied more stringently than those for medical/surgical benefits within the corresponding classification of benefits

The above analyses must be reported by carriers, the reports at a minimum must:

- Identify the factors used to determine whether a NQTL will apply to a benefit, including factors that were considered but rejected
- Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on to design NQTL
- Provide the analyses and results of the analyses
- Disclose the specific findings and conclusions that indicate that the state is in compliance with state law and the MHPAEA

By October 1, 2019 HCPF is to seek input from stakeholders who may have knowledge in benefit and delivery systems, utilization management, managed care contracting, data and reporting, or compliance and audits. HCPF is to consider the input received in conducting the above analyses and developing the reports. The reporting requirement continues indefinitely.

Medication-Assisted Treatment: Medicaid

Beginning January 1, 2020, each MCE that provides prescription drug benefits for SUD treatment shall:

- Not impose prior authorization requirements on any FDA-approved medication for SUD treatment

- Not impose any step therapy requirements as a prerequisite to coverage for any FDA-approved medication for SUD treatment
- Not exclude coverage for FDA-approved medications for SUD treatment and any associated counseling or wraparound services only on the grounds that the medications and services were court ordered.

Fiscal Note

The fiscal note assumes that the DOI will require an additional full-time analyst in order to compile and review the carriers' parity reporting. Similarly, HCPF will need an additional full-time administrator to carry out its required review, analysis, and reporting. Additionally, HCPF will require a full-time project manager to respond to parity-related complaints reported to the Ombudsman for Behavioral Health Access. For fiscal year 2019-2020 HCPF will need a full-time data specialist and contractor support to perform the stakeholder outreach.²¹ All HCPF costs are eligible for a 50 percent match from the federal government.

Reasons to Support

At the heart of the problem, there has been a lack of consistency in the oversight and enforcement on the part of federal and state regulators to get insurers to comply with existing parity laws. Though enforcement largely falls on states, many of their laws are not robust, and varying their standards leave wide disparities. This bill enhances the enforcement and oversight powers of the Commissioner of Insurance.

There are several very important elements in this proposal that would help insure that Coloradans receive critically needed access to behavioral health care. Ensuring that the parity requirements extend to Medicaid would help assure that those who are least able to afford health care have access to behavioral health services. Other key provisions would go a long way in equalizing treatment for behavioral health conditions and in catching up to best practices in substance use disorder care, with an anticipated significant increase in health and decrease in both suffering and family and societal costs, such as: prohibiting Medicaid managed care entities from denying payment for medically necessary and covered treatment on the basis that the covered diagnosis is not the primary diagnosis; changing definitions to be more inclusive of all medically acknowledged behavioral health disorders; removing prior authorization requirements for FDA-approved medications for SUD treatment; not allowing plans to deny coverage for SUD services and medications on the grounds that they were court-ordered; and more.

Supporters

- Mental Health Colorado

Reasons to Oppose

Some argue that parity legislation alone is not enough to fix other underlying problems in how our health system provides access to treatment of mental health and substance use disorders. In regards to network adequacy, it is essential to consider that currently, there is not an adequate supply of mental health and substance use disorder services across the required continuum of care in Colorado. Another concern is the addition of considerable reporting requirements; while some may be desirable, this level may be excessively burdensome. The administrative burden may increase the cost of managing a plan, which then, in turn, may increase premiums.

Opponents

- Any opposition has not been made publicly available.

²¹ It is unknown how or if the amendments that passed in the House Committee on Public Health Care and Human Services to make it more of an informal stakeholder input process rather than a committee will affect this portion of the fiscal note.

Other Considerations

As the federal government regulates self-funded plans under ERISA, if the federal government were to mandate that self-funded plans comply with MHPAEA requirements and remove the opt-out option for self-funded or provide essential health benefits, it could expand access to substance use treatment for about 1.3 million Coloradans. Another major hole in behavioral health coverage is that Medicare is not required to provide behavioral health services or comply with parity laws, leaving more than 775,000 Coloradans without parity protection.

Instead of requiring the Medicaid parity reporting to continue indefinitely, it may be more appropriate to include a sunset review date in order to reassess if the report is still needed in light of changing practices, norms, as well as new state and federal laws and regulations.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.