First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

REENGROSSED

This Version Includes All Amendments Adopted in the House of Introduction

LLS NO. 19-0981.02 Christy Chase x2008 **HOUSE BILL 19-1269**

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A BILL FOR AN ACT

CONCERNING MEASURES TO IMPROVE BEHAVIORAL HEALTH CARE COVERAGE PRACTICES, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)

The bill enacts the "Behavioral Health Care Coverage Modernization Act" to address issues related to coverage of behavioral, mental health, and substance use disorder services under private health insurance and the state medical assistance program (medicaid).

With regard to health insurance, the bill:

HOUSE
3rd Reading Unamended
April 17, 2019

HOUSE
Amended 2nd Reading
April 16, 2019

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

- Specifies that mandatory insurance coverage for behavioral, mental health, and substance use disorders includes coverage for the prevention of, screening for, and treatment of those disorders and must comply with the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (MHPAEA) (**section 3** of the bill);
- Requires coverage for services for behavioral, mental health, and substance use disorders to continue while a claim for the coverage is under review until the carrier notifies the covered person of the claim determination (**section 3**);
- Requires carriers to comply with treatment limitation requirements specified in federal regulations and precludes carriers from applying treatment limitations to behavioral, mental health, and substance use disorder services that do not apply to medical and surgical benefits (**section 3**);
- Requires carriers to provide an adequate network of providers that are able to provide behavioral, mental health, and substance use disorder services and to establish procedures to authorize treatment by nonparticipating providers when a participating provider is not available under network adequacy requirements (**section 3**);
- Modifies the definition of "behavioral, mental health, and substance use disorder" to include diagnostic categories listed in the mental disorders section of the International Statistical Classification of Diseases and Related Health Problems, the Diagnostic and Statistical Manual of Mental Disorders, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (**section 3**);
- Updates the required coverage related to alcohol use and behavioral health screenings to reflect the current requirements of that coverage as specified in recommendations of the United States preventive services task force (**section 3**);
- Requires the commissioner of insurance (commissioner) to disallow a carrier's requested rate increase for failure to demonstrate compliance with the MHPAEA (**section 5**);
- For purposes of denials of requests for reimbursement for behavioral, mental health, or substance use disorder services, requires carriers to include specified information about the protections included in the MHPAEA, how to contact the division of insurance or the office of the ombudsman for behavioral health access to care (office)

related to possible violations of the MHPAEA, and the right to request medical necessity criteria (**section 6**);

! For health benefit plans issued or renewed on or after January 1, 2020, requires carriers that provide coverage for an annual physical examination as a preventive health care service to also cover an annual mental wellness checkup to the same extent the physical examination is covered (**section 8**);

! Requires carriers to submit an annual parity report to the commissioner (**section 9**); and

! Starting January 1, 2020, requires carriers that provide prescription drug benefits for the treatment of substance use disorders to provide coverage of any FDA-approved prescription medication for treating substance use disorders without prior authorization or step therapy requirements and to place all covered substance use disorder prescription medications on the lowest tier of the drug formulary, and precludes those carriers from excluding coverage for those medications and related services solely on the grounds that they were court ordered (**section 10**).

With regard to medicaid, the bill:

! Requires the department of health care policy and financing (department) to ensure that medicaid covers behavioral, mental health, and substance use disorder services to the extent that medicaid covers a physical illness and complies with the MHPAEA (**section 11**);

! Requires the statewide system of community behavioral health care in the managed care system to require managed care entities (MCEs) to provide an adequate network of providers of behavioral, mental health, and substance use disorder services and to prohibit MCEs from denying payment for medically necessary and covered treatment for a covered behavioral health disorder diagnosis or a covered substance use disorder on the basis that the covered diagnosis is not primary (**section 12**);

! Requires the department to make MCE annual network adequacy plans public and to examine complaints from the office regarding compliance with the requirements of the bill or the MHPAEA (**section 12**);

! Requires MCEs to include specified statements regarding the applicability of the MHPAEA to the managed care system in medicaid and how to contact the office regarding possible violations of the MHPAEA (**section 14**);

! Requires MCEs to submit specified data to the department regarding behavioral health services utilization by groups that experience health disparities, denial rates for behavioral health services requiring prior authorization, and behavioral health provider directories (**section 15**);

- Requires the department to submit an annual parity report to the specified committees of the general assembly (**section 15**); and
- Starting January 1, 2020, requires an MCE that provides prescription drug benefits for the treatment of substance use disorders to provide coverage of any FDA-approved prescription medication for treating substance use disorders without prior authorization or step therapy requirements and precludes those MCEs from excluding coverage for those medications and related services solely on the grounds that they were court ordered (**section 16**).

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

SECTION 1. Short title. The short title of this act is the "Behavioral Health Care Coverage Modernization Act".

SECTION 2. In Colorado Revised Statutes, 10-16-102, **add** (43.5) as follows:

10-16-102. Definitions. As used in this article 16, unless the context otherwise requires:

(43.5) "MHPAEA" MEANS THE FEDERAL "PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008", PUB.L. 110-343, AS AMENDED, AND ALL OF ITS IMPLEMENTING AND RELATED REGULATIONS.

SECTION 3. In Colorado Revised Statutes, 10-16-104, **amend** (5.5)(a)(I), (5.5)(a)(IV), (5.5)(b), (5.5)(c), and (18)(b)(I); and **add** (5.5)(a)(V) and (5.5)(d) as follows:

10-16-104. Mandatory coverage provisions - definitions - rules. (5.5) **Behavioral, mental health, and substance use disorders - rules.** (a) (I) Every health benefit plan subject to part 2, 3, or 4 of this article 16, except those described in section 10-16-102 (32)(b), must provide coverage for the PREVENTION OF, SCREENING FOR, AND treatment of ~~both biologically based mental health disorders and~~ behavioral, mental health, ~~or~~ AND substance use disorders that is no less extensive than the coverage provided for ~~a~~ ANY physical illness AND THAT COMPLIES WITH THE REQUIREMENTS OF THE MHPAEA.

(IV) ~~As used in this subsection (5.5):~~

~~(A) "Behavioral, mental health, or substance use disorder" means post-traumatic stress disorder, substance use disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, general anxiety disorder, and autism spectrum disorders, as defined in subsection (1.4)(a)(III) of this section.~~

~~(B) "Biologically based mental health disorder" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder~~ IN THE EVENT OF A CONCURRENT REVIEW FOR A CLAIM FOR COVERAGE OF 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 COVERED PERSON OF THE DETERMINATION ON THE CLAIM.

(V) A CARRIER OFFERING A HEALTH BENEFIT PLAN SUBJECT TO THE REQUIREMENTS OF THIS SUBSECTION (5.5) SHALL:

(A) COMPLY WITH THE NONQUANTITATIVE TREATMENT LIMITATION REQUIREMENTS SPECIFIED IN 45 CFR 146.136 (c)(4), OR ANY SUCCESSOR REGULATION, REGARDING ANY LIMITATIONS THAT ARE NOT EXPRESSED NUMERICALLY BUT OTHERWISE LIMIT THE SCOPE OR DURATION

OF BENEFITS FOR TREATMENT, WHICH, IN ADDITION TO THE LIMITATIONS AND EXAMPLES LISTED IN 45 CFR 146.136 (c)(4)(ii) AND (c)(4)(iii), OR ANY SUCCESSOR REGULATION, AND 78 FR 68246, INCLUDE THE METHODS BY WHICH THE CARRIER ESTABLISHES AND MAINTAINS ITS PROVIDER NETWORKS PURSUANT TO SECTION 10-16-704 AND RESPONDS TO DEFICIENCIES IN THE ABILITY OF ITS NETWORKS TO PROVIDE TIMELY ACCESS TO CARE;

(B) COMPLY WITH THE FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS SPECIFIED IN 45 CFR 146.136 (c)(2) AND (c)(3), OR ANY SUCCESSOR REGULATION;

(C) NOT APPLY ANY NONQUANTITATIVE TREATMENT LIMITATIONS TO BENEFITS FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS THAT ARE NOT APPLIED TO MEDICAL AND SURGICAL BENEFITS WITHIN THE SAME CLASSIFICATION OF BENEFITS;

(D) 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; AND

(E) 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 THIS SUBSECTION (5.5) 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.

(b) The commissioner may adopt rules as necessary to ensure that this subsection (5.5) is implemented and administered in compliance with federal law AND SHALL ADOPT RULES TO ESTABLISH REASONABLE TIME PERIODS FOR VISITS WITH A PROVIDER FOR TREATMENT OF A BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER AFTER AN INITIAL VISIT WITH A PROVIDER.

(c) A ~~health care service plan issued by an entity subject to part 4 of this article~~ CARRIER OFFERING A MANAGED CARE PLAN THAT DOES NOT COVER SERVICES PROVIDED BY AN OUT-OF-NETWORK PROVIDER may provide that the benefits required by this subsection (5.5) are covered benefits ~~only~~ if the services are rendered by a provider who is designated by and affiliated with the ~~health maintenance organization~~ MANAGED CARE PLAN ONLY IF THE SAME REQUIREMENT APPLIES FOR SERVICES FOR A PHYSICAL ILLNESS.

(d) AS USED IN THIS SUBSECTION (5.5), "BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER":

(I) MEANS 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:

(A) THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS;

(B) THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS; OR

(C) THE DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD; AND

(II) INCLUDES AUTISM SPECTRUM DISORDERS, AS DEFINED IN SUBSECTION (1.4)(a)(III) OF THIS SECTION.

(18) **Preventive health care services.** (b) The coverage required by this subsection (18) must include preventive health care services for the following, in accordance with the A or B recommendations of the task force for the particular preventive health care service:

(I) UNHEALTHY alcohol use ~~disorder~~ screening ~~and behavioral counseling interventions~~ for adults, DEPRESSION SCREENING FOR ADOLESCENTS AND ADULTS, AND PERINATAL MATERNAL COUNSELING FOR PERSONS AT RISK. THE SERVICES SPECIFIED IN THIS SECTION MAY BE PROVIDED by A primary care ~~providers~~ PROVIDER, BEHAVIORAL HEALTH CARE PROVIDER, AS DEFINED IN SECTION 25-1.5-502 (1.3), OR MENTAL HEALTH PROFESSIONAL LICENSED OR CERTIFIED PURSUANT TO ARTICLE 43 OF TITLE 12.

SECTION 4. In Colorado Revised Statutes, 10-16-104.8, **amend** (3) as follows:

10-16-104.8. Behavioral, mental health, or substance use disorder services coverage - court-ordered. (3) For purposes of this section, "behavioral, mental health, or substance use disorder services" includes THE PREVENTION OF, SCREENING FOR, AND treatment ~~for biologically based mental health disorders and~~ OF behavioral, mental health, or substance use disorders as described in section 10-16-104 (5.5).

SECTION 5. In Colorado Revised Statutes, 10-16-107, **amend** (3)(a)(IV) and (3)(a)(V); and **add** (3)(a)(VI) as follows:

10-16-107. Rate filing regulation - benefits ratio - rules. (3) (a) The commissioner shall disapprove the requested rate increase if any of the following apply:

(IV) The actuarial reasons and data based upon Colorado claims experience and data, when available, do not justify the necessity for the requested rate increase; ~~or~~

(V) The rate filing is incomplete; OR

(VI) THE RATE FILING FAILS TO DEMONSTRATE COMPLIANCE WITH THE MHPAEA. THE COMMISSIONER SHALL ADOPT RULES TO ESTABLISH THE PROCESS AND TIMELINE FOR CARRIERS TO DEMONSTRATE COMPLIANCE WITH THE MHPAEA IN ESTABLISHING THEIR RATES.

SECTION 6. In Colorado Revised Statutes, 10-16-113, **add** (3)(c) as follows:

10-16-113. Procedure for denial of benefits - internal review - rules. (3) (c) IN ADDITION TO THE REQUIREMENTS SPECIFIED IN SUBSECTIONS (3)(a) AND (3)(b) OF THIS SECTION, UNLESS A DENIAL IS BASED ON NONPAYMENT OF PREMIUMS, A DENIAL OF REIMBURSEMENT FOR SERVICES FOR THE PREVENTION OF, SCREENING FOR, OR TREATMENT OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS UNDER A HEALTH BENEFIT PLAN MUST INCLUDE THE FOLLOWING, IN PLAIN LANGUAGE:

(I) A STATEMENT EXPLAINING THAT COVERED PERSONS ARE

PROTECTED UNDER THE MHPAEA, WHICH PROVIDES THAT LIMITATIONS PLACED ON ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS MAY BE NO GREATER THAN ANY LIMITATIONS PLACED ON ACCESS TO MEDICAL AND SURGICAL BENEFITS;

(II) A STATEMENT PROVIDING INFORMATION ABOUT CONTACTING THE DIVISION OR THE OFFICE OF THE OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE ESTABLISHED PURSUANT TO PART 3 OF ARTICLE 80 OF TITLE 27 IF THE COVERED PERSON BELIEVES HIS OR HER RIGHTS UNDER THE MHPAEA HAVE BEEN VIOLATED; AND

(III) A STATEMENT SPECIFYING THAT COVERED PERSONS ARE ENTITLED, UPON REQUEST TO THE CARRIER AND FREE OF CHARGE, TO A COPY OF THE MEDICAL NECESSITY CRITERIA FOR ANY BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFIT.

SECTION 7. In Colorado Revised Statutes, 10-16-124.5, **amend** (8)(b) as follows:

10-16-124.5. Prior authorization form - drug benefits - rules of commissioner - definition. (8) As used in this section:

(b) "Urgent prior authorization request" means

~~(I)~~ a request for prior authorization of a drug benefit that, based on the reasonable opinion of the prescribing provider with knowledge of the covered person's medical condition, if determined in the time allowed for nonurgent prior authorization requests, could:

~~(A)~~ (I) Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

~~(B)~~ (II) Subject the covered person to severe pain that cannot be adequately managed without the drug benefit that is the subject of the prior authorization request. ~~or~~

~~(II) A request for prior authorization for medication-assisted treatment for substance use disorders.~~

SECTION 8. In Colorado Revised Statutes, 10-16-139, **add** (5) as follows:

10-16-139. Access to care - rules. (5) **Annual mental wellness checkups.** A HEALTH BENEFIT PLAN THAT IS ISSUED OR RENEWED IN THIS STATE ON OR AFTER JANUARY 1, 2020, THAT PROVIDES COVERAGE FOR AN ANNUAL PHYSICAL EXAMINATION AS A PREVENTIVE HEALTH CARE SERVICE PURSUANT TO SECTION 10-16-104 (18) SHALL INCLUDE COVERAGE AND REIMBURSEMENT FOR BEHAVIORAL HEALTH SCREENINGS USING A VALIDATED SCREENING TOOL FOR BEHAVIORAL HEALTH, WHICH COVERAGE AND REIMBURSEMENT IS NO LESS EXTENSIVE THAN THE COVERAGE AND REIMBURSEMENT FOR THE ANNUAL PHYSICAL EXAMINATION.

SECTION 9. In Colorado Revised Statutes, 10-16-147, **amend** (1)(a) introductory portion and (2); and **add** (3) and (4) as follows:

10-16-147. Parity reporting - commissioner - carriers - rules - examination of complaints. (1) (a) By ~~March 1, 2019~~ JUNE 1, 2020, and ~~every other March 1~~ BY EACH JUNE 1 thereafter, the commissioner shall submit a written report TO THE HEALTH AND INSURANCE COMMITTEE AND THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, AND TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, OR ITS SUCCESSOR COMMITTEE, and provide a presentation of the report to ~~the general assembly~~ THOSE LEGISLATIVE COMMITTEES BEFORE THE NEXT REGULAR LEGISLATIVE SESSION THAT FOLLOWS SUBMITTAL OF THE REPORT, that:

(2) ~~As used in this section, "MHPAEA" means the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", Pub.L. 110-343, as amended.~~ A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN THAT IS SUBJECT TO SECTION 10-16-104 (5.5) SHALL SUBMIT TO THE COMMISSIONER AND MAKE AVAILABLE TO THE PUBLIC, BY MARCH 1, 2020, AND BY EACH MARCH 1 THEREAFTER, A REPORT THAT CONTAINS THE FOLLOWING INFORMATION FOR THE PRIOR CALENDAR YEAR:

(a) DATA THAT DEMONSTRATES PARITY COMPLIANCE FOR ADVERSE DETERMINATIONS REGARDING CLAIMS FOR BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER SERVICES AND INCLUDES THE TOTAL NUMBER OF ADVERSE DETERMINATIONS FOR SUCH CLAIMS;

(b) A DESCRIPTION OF THE PROCESS USED TO DEVELOP OR SELECT:

(I) THE MEDICAL NECESSITY CRITERIA USED IN DETERMINING BENEFITS FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS; AND

(II) THE MEDICAL NECESSITY CRITERIA USED IN DETERMINING MEDICAL AND SURGICAL BENEFITS;

(c) IDENTIFICATION OF ALL NONQUANTITATIVE TREATMENT LIMITATIONS THAT ARE APPLIED TO BENEFITS FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS AND TO MEDICAL AND SURGICAL BENEFITS WITHIN EACH CLASSIFICATION OF BENEFITS; AND

(d) (I) THE RESULTS OF ANALYSES DEMONSTRATING THAT, FOR MEDICAL NECESSITY CRITERIA DESCRIBED IN SUBSECTION (2)(b) OF THIS SECTION AND FOR EACH NONQUANTITATIVE TREATMENT LIMITATION IDENTIFIED IN SUBSECTION (2)(c) OF THIS SECTION, AS WRITTEN AND IN OPERATION, THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR

OTHER FACTORS USED IN APPLYING THE MEDICAL NECESSITY CRITERIA AND EACH NONQUANTITATIVE TREATMENT LIMITATION TO BENEFITS FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS 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 NONQUANTITATIVE TREATMENT LIMITATION TO MEDICAL AND SURGICAL BENEFITS WITHIN THE CORRESPONDING CLASSIFICATION OF BENEFITS.

(II) A CARRIER'S REPORT ON THE RESULTS OF THE ANALYSES SPECIFIED IN THIS SUBSECTION (1)(d) MUST, AT A MINIMUM:

(A) IDENTIFY THE FACTORS USED TO DETERMINE WHETHER A NONQUANTITATIVE TREATMENT LIMITATION WILL APPLY TO A BENEFIT, INCLUDING FACTORS THAT WERE CONSIDERED BUT REJECTED;

(B) IDENTIFY AND DEFINE THE SPECIFIC EVIDENTIARY STANDARDS USED TO DEFINE THE FACTORS AND ANY OTHER EVIDENCE RELIED ON IN DESIGNING EACH NONQUANTITATIVE TREATMENT LIMITATION;

(C) PROVIDE THE COMPARATIVE ANALYSES, INCLUDING THE RESULTS OF THE ANALYSES, PERFORMED TO DETERMINE THAT THE PROCESSES AND STRATEGIES USED TO DESIGN EACH NONQUANTITATIVE TREATMENT LIMITATION, AS WRITTEN, AND THE WRITTEN PROCESSES AND STRATEGIES USED TO APPLY EACH NONQUANTITATIVE 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 EACH NONQUANTITATIVE TREATMENT LIMITATION, AS WRITTEN, AND THE WRITTEN PROCESSES AND STRATEGIES USED TO APPLY

EACH NONQUANTITATIVE TREATMENT LIMITATION FOR MEDICAL AND SURGICAL BENEFITS;

(D) PROVIDE THE COMPARATIVE ANALYSES, INCLUDING THE RESULTS OF THE ANALYSES, PERFORMED TO DETERMINE THAT THE PROCESSES AND STRATEGIES USED TO APPLY EACH NONQUANTITATIVE 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 EACH NONQUANTITATIVE TREATMENT LIMITATION, IN OPERATION, FOR MEDICAL AND SURGICAL BENEFITS; AND

(E) 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 SECTION 10-16-104 (5.5) AND THE MHPAEA.

(3) THE COMMISSIONER SHALL ADOPT RULES AS NECESSARY TO IMPLEMENT THE REPORTING REQUIREMENTS OF SUBSECTION (2) OF THIS SECTION, INCLUDING RULES TO SPECIFY THE FORM AND MANNER OF CARRIER REPORTS.

(4) IF THE COMMISSIONER RECEIVES A COMPLAINT FROM THE OFFICE OF THE OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE ESTABLISHED PURSUANT TO PART 3 OF ARTICLE 80 OF TITLE 27 THAT RELATES TO A POSSIBLE VIOLATION OF SECTION 10-16-104 (5.5) OR THE MHPAEA, THE COMMISSIONER SHALL EXAMINE THE COMPLAINT, AS REQUESTED BY THE OFFICE, AND SHALL REPORT TO THE OFFICE IN A TIMELY MANNER ANY ACTION TAKEN BY THE COMMISSIONER RELATED TO THE COMPLAINT.

SECTION 10. In Colorado Revised Statutes, **add** 10-16-148 and

10-16-149 as follows:

10-16-148. Medication-assisted treatment - limitations on carriers - definition. (1) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, BEGINNING JANUARY 1, 2020, A CARRIER THAT PROVIDES PRESCRIPTION DRUG BENEFITS FOR THE TREATMENT OF SUBSTANCE USE DISORDERS SHALL, FOR PRESCRIPTION MEDICATIONS THAT ARE ON THE CARRIER'S FORMULARY:

(a) NOT IMPOSE PRIOR AUTHORIZATION REQUIREMENTS ON ANY PRESCRIPTION MEDICATION APPROVED BY THE FDA FOR THE TREATMENT OF SUBSTANCE USE DISORDERS;

(b) 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;

(c) PLACE AT LEAST ONE COVERED PRESCRIPTION MEDICATION APPROVED BY THE FDA FOR THE TREATMENT OF SUBSTANCE USE DISORDERS ON THE LOWEST TIER OF THE DRUG FORMULARY DEVELOPED AND MAINTAINED BY THE CARRIER; AND

(d) 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.

(2) AS USED IN THIS SECTION, "FDA" MEANS THE FOOD AND DRUG ADMINISTRATION IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

10-16-149. Commissioner report - parity effects on premiums

- repeal. (1) BY DECEMBER 1, 2022, THE COMMISSIONER SHALL SUBMIT A REPORT TO THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND THE HOUSE OF REPRESENTATIVES HEALTH AND INSURANCE COMMITTEE AND PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE, OR THEIR SUCCESSOR COMMITTEES, REGARDING THE EFFECTS ON PREMIUMS RESULTING FROM CHANGES ENACTED BY HOUSE BILL 19-1269 IN REQUIRED HEALTH CARE COVERAGE FOR THE PREVENTION OF, SCREENING FOR, AND TREATMENT OF BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS AND NETWORK ADEQUACY REQUIREMENTS FOR PROVIDING THOSE SERVICES PURSUANT TO SECTION 10-16-104 (5.5) AND (18)(b)(I) AND PRESCRIPTION DRUG FORMULARY REQUIREMENTS PURSUANT TO SECTION 10-16-148.

(2) THIS SECTION IS REPEALED, EFFECTIVE MARCH 1, 2023.

SECTION 11. In Colorado Revised Statutes, 25.5-5-103, **add** (4) as follows:

25.5-5-103. Mandated programs with special state provisions - rules. (4) (a) THE STATE DEPARTMENT SHALL ENSURE THAT BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER SERVICES ARE NO LESS EXTENSIVE THAN BENEFITS FOR ANY PHYSICAL ILLNESS AND ARE IN COMPLIANCE WITH THE MHPAEA, AS DEFINED IN SECTION 25.5-5-403 (5.7), INCLUDING THE QUANTITATIVE AND NONQUANTITATIVE TREATMENT LIMITATION REQUIREMENTS SPECIFIED IN 42 CFR 438.910 (c). ON OR AFTER JANUARY 1, 2020, IF AN MCE, AS DEFINED IN SECTION 25.5-5-403 (4), DENIES COVERAGE FOR A COVERED BEHAVIORAL, MENTAL HEALTH, OR SUBSTANCE USE DISORDER BENEFIT OR SERVICE BASED ON DIAGNOSIS, THE STATE BOARD SHALL ESTABLISH, BY RULE, A PROCEDURE TO ALLOW FOR

REIMBURSEMENT OF MEDICALLY NECESSARY STATE PLAN SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM. THE STATE DEPARTMENT MAY USE MULTIPLE PAYMENT MODALITIES TO COMPLY WITH THIS SUBSECTION (4).

(b) THE STATE BOARD SHALL ADOPT RULES ESTABLISHING THE PROCEDURES FOR REIMBURSEMENT PURSUANT TO THIS SUBSECTION (4) BY JANUARY 1, 2020.

SECTION 12. In Colorado Revised Statutes, 25.5-5-402, **amend** (3)(e); and **add** (3)(g), (3)(h), (3)(i), (15), (16), and (17) as follows:

25.5-5-402. Statewide managed care system - definition - rules. (3) The statewide managed care system must include a statewide system of community behavioral health care that must:

(e) Be paid for by the state department establishing capitated rates specifically for community mental health services that account for a comprehensive continuum of needed services such as those provided by community mental health centers as defined in section 27-66-101; ~~and~~

(g) IN ADDITION TO NETWORK ADEQUACY REQUIREMENTS DETERMINED BY THE STATE DEPARTMENT, REQUIRE EACH MCE TO OFFER AN ENROLLEE AN INITIAL OR SUBSEQUENT NONURGENT CARE VISIT WITHIN A REASONABLE PERIOD WHERE MEDICALLY NECESSARY AND AT APPROPRIATE THERAPEUTIC INTERVALS, AS DETERMINED BY STATE BOARD RULE;

(h) SPECIFY THAT THE DIAGNOSIS OF AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY, A NEUROLOGICAL OR NEUROCOGNITIVE DISORDER, OR A TRAUMATIC BRAIN INJURY DOES NOT PRECLUDE AN INDIVIDUAL FROM RECEIVING A COVERED BEHAVIORAL HEALTH SERVICE; AND

(i) REQUIRE AN MCE TO COVER ALL MEDICALLY NECESSARY

COVERED TREATMENTS FOR COVERED BEHAVIORAL HEALTH DIAGNOSES, REGARDLESS OF ANY CO-OCCURRING CONDITIONS.

(15) ON OR BEFORE JULY 1, 2020, THE STATE DEPARTMENT SHALL INCLUDE UTILIZATION MANAGEMENT GUIDELINES FOR THE MCES IN THE STATE BOARD'S MANAGED CARE RULES.

(16) THE STATE DEPARTMENT SHALL PROVIDE INFORMATION ON ITS WEBSITE SPECIFYING HOW THE PUBLIC MAY REQUEST THE NETWORK ADEQUACY PLAN AND QUARTERLY NETWORK REPORTS FOR AN MCE. 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 TO ENROLLEES WITH REASONABLE PROMPTNESS. SUCH ACTIONS INCLUDE, WITHOUT LIMITATION:

(a) UTILIZING SINGLE CASE AGREEMENTS WITH OUT-OF-NETWORK PROVIDERS WHEN NECESSARY; AND

(b) USING FINANCIAL INCENTIVES TO INCREASE NETWORK PARTICIPATION.

(17) IF THE STATE DEPARTMENT RECEIVES A COMPLAINT FROM THE OFFICE OF THE OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE ESTABLISHED PURSUANT TO PART 3 OF ARTICLE 80 OF TITLE 27 THAT RELATES TO POSSIBLE VIOLATIONS OF SUBSECTION (3) OF THIS SECTION OR THE MHPAEA, THE STATE DEPARTMENT SHALL EXAMINE THE COMPLAINT, AS REQUESTED BY THE OFFICE, AND SHALL REPORT TO THE OFFICE IN A TIMELY MANNER ANY ACTIONS TAKEN RELATED TO THE COMPLAINT.

SECTION 13. In Colorado Revised Statutes, 25.5-5-403, **add** (5.7) as follows:

25.5-5-403. Definitions. As used in this part 4, unless the context otherwise requires:

(5.7) "MHPAEA" MEANS THE FEDERAL "PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008", PUB.L. 110-343, AS AMENDED, AND ALL OF ITS IMPLEMENTING AND RELATED REGULATIONS.

SECTION 14. In Colorado Revised Statutes, 25.5-5-406.1, **add** (1)(t) as follows:

25.5-5-406.1. Required features of statewide managed care system. (1) **General features.** All medicaid managed care programs must contain the following general features, in addition to others that the federal government, state department, and state board consider necessary for the effective and cost-efficient operation of those programs:

(t) EACH MCE MUST INCLUDE THE FOLLOWING STATEMENTS PROMINENTLY IN THE ENROLLEE HANDBOOK, ON THE STATE DEPARTMENT'S WEBSITE, AND ON THE MCE'S ENROLLMENT WEBSITE:

(I) A STATEMENT INDICATING THAT THE MCE IS SUBJECT TO THE MHPAEA AND THAT A DENIAL, RESTRICTION, OR WITHHOLDING OF BENEFITS FOR BEHAVIORAL HEALTH SERVICES THAT ARE COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM COULD BE A POTENTIAL VIOLATION OF THAT ACT; AND

(II) A STATEMENT DIRECTING THE ENROLLEE TO CONTACT THE OFFICE OF THE OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE ESTABLISHED PURSUANT TO PART 3 OF ARTICLE 80 OF TITLE 27 IF THE ENROLLEE WANTS FURTHER ASSISTANCE PURSUING ACTION REGARDING POTENTIAL PARITY VIOLATIONS, WHICH STATEMENT MUST INCLUDE THE TELEPHONE NUMBER FOR THE OFFICE AND A LINK TO THE OFFICE'S

WEBSITE.

SECTION 15. In Colorado Revised Statutes, **add** 25.5-5-421 and 25.5-5-422 as follows:

25.5-5-421. Parity reporting - state department - public input. (1) THE STATE DEPARTMENT SHALL REQUIRE EACH MCE CONTRACTED WITH THE STATE DEPARTMENT TO DISCLOSE ALL NECESSARY INFORMATION IN ORDER FOR THE STATE DEPARTMENT, BY JUNE 1, 2020, AND BY EACH JUNE 1 THEREAFTER, TO SUBMIT A REPORT TO THE HEALTH AND INSURANCE COMMITTEE AND THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, AND TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, OR ITS SUCCESSOR COMMITTEE, REGARDING BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER PARITY. THE REPORT MUST CONTAIN THE FOLLOWING INFORMATION FOR THE PRIOR CALENDAR YEAR:

(a) A DESCRIPTION OF THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFITS AND THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MEDICAL AND SURGICAL BENEFITS;

(b) IDENTIFICATION OF ALL NONQUANTITATIVE TREATMENT LIMITATIONS THAT ARE APPLIED TO BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFITS AND TO MEDICAL AND SURGICAL BENEFITS WITHIN EACH CLASSIFICATION OF BENEFITS AND A STATEMENT THAT THE STATE IS COMPLYING WITH 42 U.S.C. SEC. 300gg-26 (a)(3)(A)(ii), AS REQUIRED BY 42 U.S.C. SEC. 1396u-2 (b)(8), PROHIBITING

THE APPLICATION OF NONQUANTITATIVE TREATMENT LIMITATIONS TO BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER BENEFITS THAT DO NOT APPLY TO MEDICAL AND SURGICAL BENEFITS WITHIN ANY CLASSIFICATION OF BENEFITS;

(c) (I) THE RESULTS OF ANALYSES DEMONSTRATING THAT, FOR THE MEDICAL NECESSITY CRITERIA DESCRIBED IN SUBSECTION (1)(a) OF THIS SECTION AND EACH NONQUANTITATIVE TREATMENT LIMITATION IDENTIFIED IN SUBSECTION (1)(b) OF THIS SECTION, AS WRITTEN AND IN OPERATION, THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR OTHER FACTORS USED IN APPLYING THE MEDICAL NECESSITY CRITERIA AND EACH NONQUANTITATIVE TREATMENT LIMITATION TO BENEFITS FOR BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDERS 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 NONQUANTITATIVE TREATMENT LIMITATION TO MEDICAL AND SURGICAL BENEFITS WITHIN THE CORRESPONDING CLASSIFICATION OF BENEFITS.

(II) A REPORT ON THE RESULTS OF THE ANALYSES SPECIFIED IN THIS SUBSECTION (1)(c) MUST, AT A MINIMUM:

(A) IDENTIFY THE FACTORS USED TO DETERMINE THAT A NONQUANTITATIVE TREATMENT LIMITATION WILL APPLY TO A BENEFIT, INCLUDING FACTORS THAT WERE CONSIDERED BUT REJECTED;

(B) IDENTIFY AND DEFINE THE SPECIFIC EVIDENTIARY STANDARDS USED TO DEFINE THE FACTORS AND ANY OTHER EVIDENCE RELIED ON IN DESIGNING EACH NONQUANTITATIVE TREATMENT LIMITATION;

(C) PROVIDE THE COMPARATIVE ANALYSES, INCLUDING THE

RESULTS OF THE ANALYSES, PERFORMED TO DETERMINE THAT THE PROCESSES AND STRATEGIES USED TO DESIGN EACH NONQUANTITATIVE TREATMENT LIMITATION, AS WRITTEN, AND THE WRITTEN PROCESSES AND STRATEGIES USED TO APPLY EACH NONQUANTITATIVE 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 EACH NONQUANTITATIVE TREATMENT LIMITATION, AS WRITTEN, AND THE WRITTEN PROCESSES AND STRATEGIES USED TO APPLY EACH NONQUANTITATIVE TREATMENT LIMITATION FOR MEDICAL AND SURGICAL BENEFITS;

(D) PROVIDE THE COMPARATIVE ANALYSES, INCLUDING THE RESULTS OF THE ANALYSES, PERFORMED TO DETERMINE THAT THE PROCESSES AND STRATEGIES USED TO APPLY EACH NONQUANTITATIVE 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 EACH NONQUANTITATIVE TREATMENT LIMITATION, IN OPERATION, FOR MEDICAL AND SURGICAL BENEFITS; AND

(E) DISCLOSE THE SPECIFIC FINDINGS AND CONCLUSIONS THAT INDICATE THAT THE STATE IS IN COMPLIANCE WITH THIS SECTION AND WITH THE MHPAEA.

(2) BY OCTOBER 1, 2019, FOR PURPOSES OF OBTAINING MEANINGFUL PUBLIC INPUT DURING THE ASSESSMENT PROCESS DESCRIBED IN SUBSECTION (1) OF THIS SECTION, THE STATE DEPARTMENT SHALL SEEK INPUT FROM STAKEHOLDERS WHO MAY HAVE COMPETENCY IN BENEFIT AND DELIVERY SYSTEMS, UTILIZATION MANAGEMENT, MANAGED CARE

CONTRACTING, DATA AND REPORTING, OR COMPLIANCE AND AUDITS. THE STATE DEPARTMENT SHALL CONSIDER THE INPUT RECEIVED IN CONDUCTING THE ANALYSES AND DEVELOPING THE REPORT PURSUANT TO SUBSECTION (1) OF THIS SECTION.

(3) NOTWITHSTANDING SECTION 24-1-136 (11)(a)(I), THE REPORTING REQUIREMENT SPECIFIED IN THIS SECTION CONTINUES INDEFINITELY.

(4) THE STATE DEPARTMENT SHALL CONTRACT WITH AN EXTERNAL QUALITY REVIEW ORGANIZATION AT LEAST ANNUALLY TO MONITOR MCES' UTILIZATION MANAGEMENT PROGRAMS AND POLICIES, INCLUDING THOSE THAT GOVERN ADVERSE DETERMINATIONS, TO ENSURE COMPLIANCE WITH THE MHPAEA. THE QUALITY REVIEW REPORT MUST BE READILY AVAILABLE TO THE PUBLIC.

25.5-5-422. Medication-assisted treatment - limitations on MCEs - definition. (1) AS USED IN THIS SECTION, "FDA" MEANS THE FOOD AND DRUG ADMINISTRATION IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(2) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, BEGINNING JANUARY 1, 2020, EACH MCE THAT PROVIDES PRESCRIPTION DRUG BENEFITS FOR THE TREATMENT OF SUBSTANCE USE DISORDERS SHALL:

(a) NOT IMPOSE ANY PRIOR AUTHORIZATION REQUIREMENTS ON ANY PRESCRIPTION MEDICATION APPROVED BY THE FDA FOR THE TREATMENT OF SUBSTANCE USE DISORDERS;

(b) NOT IMPOSE ANY STEP THERAPY REQUIREMENTS AS A PREREQUISITE TO AUTHORIZING COVERAGE FOR A PRESCRIPTION MEDICATION APPROVED BY THE FDA FOR THE TREATMENT OF SUBSTANCE

USE DISORDERS; AND

(c) 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.

SECTION 16. Applicability. (1) Except as specified in subsection (2) of this section, this act applies to conduct occurring on or after the effective date of this act.

(2) Sections 3 and 4 of this act apply to health benefit plans issued or renewed on or after the effective date of this act.

SECTION 17. Appropriation. (1) For the 2019-20 state fiscal year, $181,751 is appropriated to the department of health care policy and financing. Of this appropriation $123,590 is from the general fund and $58,161 is from the healthcare affordability and sustainability fee cash fund created in section 25.5-4-402.4 (5)(a), C.R.S. To implement this act, the department may use this appropriation as follows:

(a) $84,771, which consists of $57,644 from the general fund and $27,127 from the healthcare affordability and sustainability fee cash fund, for use by the executive director's office for personal services, which amount is based on an assumption that the department will require an additional 3.0 FTE;

(b) $8,480, which consists of $5,766 from the general fund and $2,714 from the healthcare affordability and sustainability fee cash fund, for use by the executive director's office for operating expenses; and

(c) $88,500, which consists of $60,180 from the general fund and $28,320 from the healthcare affordability and sustainability fee cash fund, for use by the executive director's office for general professional services and special projects.

(2) For the 2019-20 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive $181,750 in federal funds to implement this act, which amount is included for informational purposes only. The appropriation in subsection (1) of this section is based on the assumption that the department will receive this amount of federal funds to be used as follows:

(a) $84,771 for use by the executive director's office for personal services;

(b) $8,479 for use by the executive director's office for operating expenses; and

(c) $88,500 for use by the executive director's office for general professional services and special projects.

(3) For the 2019-20 state fiscal year, $88,248 is appropriated to the department of regulatory agencies for use by the division of insurance. This appropriation is from the division of insurance cash fund created in section 10-1-103 (3), C.R.S. To implement this act, the division may use this appropriation as follows:

(a) $82,500 for personal services, which amount is based on an assumption that the division will require an additional 1.1 FTE; and

(b) $5,748 for operating expenses.

SECTION 18. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.