

**Health District**  
OF NORTHERN LARIMER COUNTY  
**BOARD OF DIRECTORS**  
**SPECIAL MEETING**  
**February 13, 2020**

**Health District Office Building**  
120 Bristlecone Drive, Fort Collins

**MINUTES**

**BOARD MEMBERS PRESENT:** Molly Gutilla, MS DrPH, Board Vice President  
Joseph Prows, MD MPH, Board Treasurer

**BOARD MEMBERS PRESENT  
BY PHONE:**

Celeste Kling, J.D., Board Secretary  
Faraz Naqvi, MD, Liaison to UCH-North/PVHS Board

**BOARD MEMBERS ABSENT:** Michael D. Liggett, Esq., Board President

**Staff Present:**

Carol Plock, Executive Director  
James Stewart, Medical Director  
Richard Cox, Communications Director  
Lorraine Haywood, Finance Director  
Dana Turner, Dental Services Director  
Anita Benavidez, Executive Assistant

**CALL TO ORDER; APPROVAL OF AGENDA**

Board Vice President Molly Gutilla called the meeting to order at 4:10 p.m.

Director Prows requested that we add to the agenda a brief discussion about the Board getting an update on health district policy with respect to treatment of transgender patients.

**MOTION: To approve the agenda as Amended**  
*Moved/Seconded/Carried Unanimously (4-0)*

**PUBLIC COMMENT**

None

**DISCUSSION AND ACTIONS**

Director Prows requested that the Board be given an update on the Health District's policy, software, and staff training regarding treatment of transgender patients. The issue will be added to an already-planned presentation from the Equity, Diversity, and Inclusion Task Force during the March Board meeting.

**Policy**

***Health District Policy***

- **Nondiscrimination Statement and EEO**

Ms. Plock noted that changes to the EEO policy and notice of nondiscrimination statement are presented as a follow-up to the discussion in the January 28 Board Meeting, in which there was a question as to whether there were legal implications to using the term “protected veteran” rather than just “veteran”. The Health District attorney indicated that use of the term “protected” allows the health district to legally rely on that language but it is not essential. The attorney also recommended the addition of “marital status,” as well as the other changes indicated in the 2/7 memo to the Board.

It was noted that this policy covers not only what is required by law, but goes beyond that, and it will be important that we have further communication and education about how the policy is implemented in actuality. The decision was made to change the language in the second line of the Notice of Non-Discrimination, so that it reads “not to discriminate” rather than “to not discriminate.”

**MOTION:** To approve the EEO policy and non-discrimination statement, with the amendment to the proposed Notice of Non-Discrimination utilizing the wording “not to discriminate.”  
*Moved/Seconded/Carried Unanimously*

### *State Legislative Proposals*

Ms. Williams updated the status of the legislative session: 37 days in with 83 days left; 460 bills introduced (compared to 311 bills at this point last year); and 38 killed. She noted that 200 of these bills are bipartisan bills.

Updates to Bills Previously Discussed:

- **HB20-1001: Nicotine Product Regulation**  
The bill has been amended, allowing vending machines in gaming establishments, affirmative defense (upon meeting four requirements), clarification that employees can be under 21 but must be older than 18; and the enforcement period for violations was changed from 36 months back to 24 months.
- **SB20-065: Mobile Devices While Driving**  
The definition of “use” has been amended, using nearly the exact language that we provided from Georgia. It has passed out of committee.

New Bills:

- **HB20-1006: Early Childhood Mental Health Consultants**  
The bill requires the Department of Human Services to develop and implement a statewide program of early childhood mental health consultants. Colorado currently has a small program, but this would expand it, developing the use of more structure and best practices, thus increasing the number of qualified, trained professionals who provide high quality services.

**MOTION:** To support HB20-1006: Early Childhood Mental Health Consultants.  
*Moved/Seconded/Carried Unanimously*

- **SB20-001: Expand Behavioral Health Training for K-12 Educators**  
The bill requires the Colorado Department of Education to offer a train-the-trainer program for employees, in order to expand behavioral health training for kindergarten through twelfth

grade educators. The intent is to expand Youth Mental Health First Aid (MHFA) in Colorado, eventually enacting Teen MHFA (which is for students) at the high schools. Sites eligible for TMHFA must have at least 10% of their adult staff trained in YMHFA. A Board member noted that, with the rate of teen suicides, anything we can do is a positive step forward.

**MOTION: To support SB20-001: Expand Behavioral Health Training for K-12 Educators**

*Moved/Seconded/Carried Unanimously*

- **SB20-029: Cost of Living Adjustment for Colorado Works Program**

This bill would increase the amount of Basic Cash Assistance in the Temporary Assistance for Needy Families (TANF) program, called Colorado Works. The amount has not changed much since 1996, and the purchasing power is significantly lower than it was back then. It was amended from using the federal COLA (cost of living adjustment) to an annual increase of 1.5%. Funds will come from a reserve fund that currently has about \$180M in it; this change is anticipated to cost an additional \$2-\$3M per year. If the balance of the reserve falls below \$34M, the JBC is to consider other/additional sources of funding.

**MOTION: To support SB20-029: Cost of Living Adjustment for Colorado Works Program**

*Moved/Seconded/Carried Unanimously*

- **HB20-1008: Health Care Cost-Sharing Consumer Protections**

The bill concerns protections for consumers who participate in health care cost-sharing arrangements (CSAs), requiring CSAs to report specific information to the Commission of Insurance, provide disclosures to consumers, etc. CSAs are cost-sharing operations where members pool their money and the group decides what gets doled out for different procedures; it is not insurance, and coverage is not guaranteed. One such ‘ministry’ has been banned from operating in Colorado and Texas, due in part to its marketing itself as health insurance. The bill’s main intent is to require disclosure. Amendments are likely, including potentially removing the proposed prohibition on enrolling an individual or a group into a CSA during the Marketplace open enrollment period. There is significant consumer participation in Colorado and in Larimer County.

**MOTION: To strongly support HB20-1008: Health Care Cost-Sharing Consumer Protections**

*Moved/Seconded/Carried Unanimously*

- **SB20-127: Committee Actuarial Review Health Care Plan Legislation**

This bill would create a health benefit plan design change review committee, which would conduct actuarial reviews of legislation affecting health benefit plan requirements. Because the proposal was recently introduced and has multiple possible implications, staff did not make a recommendation, instead asking that the Board ponder and discuss the proposal prior to taking any position.

In discussion, the following points were considered: The concept of having more information before making benefit changes seems like a good one, but the implications of this requirement are many. The addition of new benefits can change health insurance premiums – for example, in 2020, there is a proposal to require insurance to cover infertility treatment. On the other hand, actuarial analyses cost considerable money and time; would it

be worth the investment? Such analyses are complex, and their results depend on assumptions, so would it be possible to estimate a burden of cost for every type of proposal? Is it appropriate for the state to fund analyses cost? Could quality analyses be done within the limited time of a legislative session? This bill proposes only an immediate economic cost; it doesn't take into account the value of the impact on health. In the end, the Board felt that there were too many questions outstanding to be able to support, or take any position on, the bill. They chose to take a neutral position, clarifying that a neutral position, as opposed to no position, means the bill has been reviewed.

**MOTION: To take a neutral position on SB20-127: Committee Actuarial Review Health Care Plan Legislation**  
*Moved/Seconded/Carried Unanimously*

**Drug Price Transparency Bills:**

Ms. Williams reported that drug prices continue to increase. For Medicaid (which has protections from drug price increases that private insurers do not have), the major cost increase is for specialty drugs. Anthem recently reported an anticipated 12.6% increase for drugs in 2020 in the individual market, noting that utilization increase is only 2.8% of that 12.6%. In comparison, Anthem expects an increase of only 4.6% for hospitals and doctors.

- **SB20-107: Drug Production Costs Transparency Analysis Report**

This bill is deemed the “Prescription Drug Production Costs Transparency Act of 2020.” Sponsored by Senator Ginal, it would require the Department of Health Care Policy and Financing (HCPF) to collect, analyze, and report prescription drug production cost data from prescription drug manufacturers on the 20 highest-cost prescription drugs per course of therapy and the 20 highest-cost prescription drugs by volume purchased or paid for by key state agencies. The intent is to understand the justification of those top 20 costs.

It lists several categories of expenses, but does not yet define them, which could lead to difficulty in comparing the reports from manufacturer to manufacturer. Another challenge could be whether the information is considered to include ‘trade secrets.’ The bill has the support of HCPF and other major health care organizations.

- **HB20-1160: Drug Price Transparency Insurance Premium Reductions**

This bill is deemed the “Colorado Prescription Drug Price Transparency Act of 2020,” requiring reporting on prescription drug costs by manufacturers, insurers, pharmacy benefit managers (PBMs), and certain nonprofit organizations, with the intent of promoting cost containment and reduction. It has been amended to include a sunset of the program in five years, to allow manufacturers to add to their reports other information they believe is important to the reasoning of the cost of the drugs, and to provide more protection for proprietary information. Manufacturers are concerned that the reports would not reflect research and development costs of failed drugs. The bill includes a 1-day advance notice by manufacturers for price increases, and was amended to clarify that manufacturers’ reports are not public record, and to remove the requirement for nonprofit reporting. The Board was asked to consider key questions, including: Would the information be likely to have an impact on future legislation or rule making or programs? Would the reporting be likely to change the practices of those players required to report? Might there be any unintended consequences? Would the benefits outweigh the cons?

In discussion, one comment was that there may be some issues with it, but the benefit of increased transparency seems to outweigh the downsides. A key question was whether the

requirement for insurers to pass on the rebates they receive to consumers would save money or not; it's a complex issue. Might it impact prices due to factors such as having to figure it out and pass it on, or changing how PBM firms or insurers structure contracts, or increasing premiums? Another question related to a requirement that manufacturers of drugs over \$50 for a course of therapy report an increase in the price of the drug if the increase in price is over 10% or more over the previous 12 months, and whether that could encourage rather than discourage continuing high increases in drug prices, given that the current inflation rate is around 2%, well under 10%.

**MOTION: To support HB20-1160: Drug Price Transparency Insurance Premium Reductions AND SB20-107: Drug Production Costs Transparency Analysis Report**  
*Moved/Seconded/Carried Unanimously*

- **Other Policy issues**

- **HB20-1092: Reimbursement to Federally Qualified Health Centers**

- This bill requires Medicaid to reimburse FQHCs for telemedicine and clinical pharmacy services. It would change funding for telemedicine from being a part of their current reimbursement to being reimbursed by fee for service. Clinical pharmacy services have been funded in the past by grants, which are ending. Both services are considered important for both health access and cost efficiencies. The initial fiscal note was published at \$4.6M in 2020/2021 and \$9M in 2021/2022, but the amounts are being challenged, because they don't include the potential savings. In discussion, it was noted that telemedicine appears to be the future of health care, and that it is receiving strong attention at the national level. It is not clear whether federal funds can be used for these services, or whether the funds would all need to be state funds.

- MOTION: To strongly support HB20-1092: Reimbursement to Federally Qualified Health Centers**  
*Moved/Seconded/Carried Unanimously*

- **Local Policy Issue**

- The letter supporting the reinstatement of Poudre School District health education requirements was sent, but there has not yet been a response from board members or the Superintendent. A few organizations had representatives at the school board's February 11 meeting to support reinstatement, but the issue was not on the agenda, and decisions have not been made yet.

- **Federal Policy Issues**

- Medicaid Block Grant: "Healthy Adult Opportunity"**. CMS provided guidance on their new 1115 waiver, which supports states in developing Medicaid Block Grant programs and allows extensive flexibility, without being bound by Federal standards for eligibility, benefits, delivery system, or program oversight. The Kaiser Family Foundation created a graphic illustrating some key components of this new Healthy Adult Opportunity Guidance falling into four main categories, including waiver financing, eligible populations, previously approved flexibility, and new flexibility. There are multiple concerns about the impact of the new guidance to those who are served by Medicaid. It could increase out-of-pocket costs for Medicaid enrollees, could destabilize the payment system for FQHCs, allow states to make changes without seeking federal approval, impose work requirements, allow for a closed prescription formulary, and more. Some organizations believe the guidance is outside the law and would result in litigation if followed. There was no open comment period.

**2021 Benefits & Payment parameters for insurance market place.** The federal administration is proposing changes in regulations that would (1) end automatic re-enrollment for low-income marketplace enrollees with \$0 premium plans, (2) make coverage effective dates for SEP enrollments be the first of the following month – regardless of enrollment date, (3) increase the proposed max out-of-pocket in 2021 to \$8,550 for a single person and \$17,100 for a family, and (4) Requiring states to report annually any state-mandated benefits applicable to the individual or small group markets that are in addition to essential health benefits beginning in year 2021. Should the federal government require states to cover the full cost of the additional benefits, it would be a significant financial burden to states. Comments are due in March.

**MOTION:** To have staff prepare a comment for submission that opposes the first and fourth items (see above) and supports the second item (see above).  
*Moved/Seconded/Carried Unanimously*

### **National Health Policy Conference Update**

Ms. Plock gave a review of highlights from speakers at the National Health Policy Conference. An initial speaker summarized both health progress and challenges: Progress: in the last twenty years, there has been significant change in the public’s and politicians’ consensus – most now support expanded access (including allowing youth to stay on their parents’ insurance until age 26, subsidized health insurance, and the expansion of Medicaid); protection from increase costs, and particularly protection from increased costs or exclusions for pre-existing conditions; and the need to innovate and find better ways, such as bi-partisan support for value-based care and seeing people as part of a complex social system. On the challenge side: Cost: commercial health insurance costs and health care costs continue to rise; surprise billing is prevalent; there are new waves of expensive new drugs and dramatic price increases for established drugs; millions are still uninsured; and health equity is still a distant goal.

Staffers from congressional offices indicated that there has been substantial bipartisan work on several issues, and remain cautiously hopeful that there may be legislative progress this year on the issues of drug pricing, surprise billing, interoperability (there are brand new standards released from the Administration this week), and the long term extension of community health care funding and funding for teaching health center graduate medical education. On surprise billing, there are three options being discussed for payment to providers out of network – a benchmark payment at the in-network rate; aiming for a benchmark but allow arbitration where each side would be able to put in a bid and the arbitrator would decide; and pure arbitration.

Other items with strong interest are telehealth, maternal mortality (a proposal is to extend Medicaid coverage in non-expansion states to 12 months for mothers), and vaping/e-cigarettes. Telehealth is viewed mostly as the future, but legislators may work on clarity to Medicaid directors about reimbursement for telehealth, though it would probably be restricted to certain use cases. Speakers gave examples of significant new technologies, including a telehealth dermatology service, a new hypertension management that operates through cellphones, and a podiatry approach that uses technology to detect diabetic foot ulcers before they clinically present.

In discussing value-based payment models, speakers reported that data indicates that we are not having a lot of success with value-based payments – some, but not a lot. Success is coming mostly not through hospital sponsored approaches, but from physician sponsored efforts. Overall, patient experience has gone up a little, hospitalizations have gone down a little. Bundled payments for medical conditions were a strikeout, but bundled payments for surgical events have been pretty good- in some cases, bringing savings of 4-5%; even up to 20%.

Targeted pay for performance has not been found to work. Asking physician practices to make different changes for each insurance plan has been a challenge; the changes being requested need to be meaningful and sustainable.

In other key presentations, social determinants of health were a key theme. Of interest to us locally is a network platform developed by Kaiser and another partner called 'Unite Us', which provides a care coordination platform between social services and health care services so information can be shared. In Colorado, Rocky Mountain Health Plan has also developed a successful care coordination platform that has been adopted on the western slope, but not here. Other efforts regarding SDoH included patient screening, and what to do when needs are found. Food security consistently is the top need indicated. In one example, they were doing extensive screening and referring people to services, but the food bank called them and reported that half their referrals were coming from that health plan, and that they couldn't support all of the additional people coming out of the screening. One health plan is testing a grocery benefit. All of these efforts are good; the challenge is that most are short-term charitable efforts that are likely to shift in the future. One speaker noted that what is really needed is an ongoing pragmatic business model. In a more lasting SDoH intervention, one health plan put in \$10M to build housing units, secured \$10M from FannieMae, and the community raised another \$200M.

The big recurrent concerns heard at the conference were: the cost of health care and health insurance; increasing drug costs (including that the Medicare out of pocket cost for consumers quadrupled from 2007 to 2011, and the considerable increase in the cost of highly utilized and required medications like insulin, and that average list price increases are 10 – 17% per year for drugs); the impact that Medicaid block grants could have on reducing health benefits for millions; and the release of the Trump budget this week, including a \$10 Trillion cut from Medicaid over a decade. Other themes included infant health, and loneliness.

In discussion, it was noted that regarding maternal mortality, women of color are dying at much higher rates than white women. Deaths occur at all stages – about one-third during pregnancy, one-third during birth, and the final third after birth. These numbers are driven by access, racism, attention at hospitals, and more. We can research Colorado specific data. One change proposed in a conference session was monitoring blood loss during birth, which might lower mortality. At the state level, HCPF has put maternal health as one of its top priorities for Medicaid enrollees, and expects that RAEs will try to get mothers into coverage as soon as they know they are pregnant.

#### **PUBLIC COMMENT (2<sup>nd</sup> opportunity)**

None.

#### **ANNOUNCEMENTS**

- February 25, 4:00 pm – Board of Directors Regular Meeting
- March 10, 4:00 pm – Board of Directors Special Meeting

#### **ADJOURN**

**MOTION: To Adjourn the Meeting**  
***Moved/Seconded/Carried Unanimously***

The meeting was adjourned at 5:50 p.m.