



BOARD OF DIRECTORS SPECIAL MEETING

**Health District of Northern Larimer County
Virtual Meeting
See connection details at end of agenda**

**Tuesday, April 13, 2021
4:00 p.m.**



BOARD OF DIRECTORS SPECIAL MEETING

April 13, 2021

4:00 pm

Virtual

AGENDA

4:00 p.m. Call to Order; Welcome to New Board Member; Introductions; Approval of Agenda
.....Michael Liggett

4:20 p.m. PUBLIC COMMENT

Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

4:25 p.m. DISCUSSION & ACTIONS

- Policy..... Alyson Williams

Brief Overview on Policy Process and Positions

State Legislative Proposals

- State Budget
- SB21-199: Remove Barriers To Certain Public Opportunities
- HB21-1150: Create the Colorado Office of New Americans
- HB21-1232: Standardized Health Benefit Plan Colorado Option
- Update on SB21-085: Actuarial Review Health Insurance Mandate Legislation
- HB21-1198: Health-care Billing Requirements for Indigent Patients

Other policy issues that may arise

5:20 p.m. DISCUSSION

- Brief Status Update, COVID and the Health District.....Carol Plock

5:25 p.m. ANNOUNCEMENTS

- April 27, 4:00 pm – Board of Directors Regular Meeting
- May 11, 4:00 p.m. – Board of Directors Special Meeting (policy)
- May 25, 4:00 p.m. – Board of Directors Regular Meeting

5:30 p.m. ADJOURN

Join Zoom Meeting

Registration is required. Click this link to register:

https://healthdistrict.zoom.us/join/tJAtdOmorTgsGtP4_yOorXYg3p8_HakSkEFq

After registering, you will receive a confirmation email containing information about joining the meeting.

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. **Public comments or input are taken only during the time on the agenda listed as 'Public Comment.'** If you choose to make comments about any agenda item or about any other topic not on the agenda, please use the following guidelines.

- **Before you begin your comments please:** Identify yourself – spell your name – state your address. Tell us whether you are addressing an agenda item, or another topic.
- **Limit your comments to five (5) minutes.**

■ MISSION ■

The Mission of the Health District of Northern Larimer County is to enhance the health of our community.

■ VISION ■

- ❑ District residents will live long and well.
- ❑ Our community will excel in health assessment, access, promotion and policy development.
 - Our practice of **assessment** will enable individuals and organizations to make informed decisions regarding health practices.
 - All Health District residents will have timely **access** to basic health services.
 - Our community will embrace the **promotion** of responsible, healthy lifestyles, detection of treatable disease, and the **prevention** of injury, disability and early death.
 - Citizens and leaders will be engaged in the creation and implementation of ongoing **systems and health policy development** at local, state, and national levels.
 - Like-minded communities across the country will emulate our successes.

■ STRATEGY ■

The Health District will take a leadership role to:

- ❑ Provide exceptional health services that address unmet needs and opportunities in our community,
- ❑ Systematically assess the health of our community, noting areas of highest priority for improvement,
- ❑ Facilitate community-wide planning and implementation of comprehensive programs,
- ❑ Educate the community and individuals about health issues,
- ❑ Use Health District funds and resources to leverage other funds and resources for prioritized projects, and avoid unnecessary duplication of services,
- ❑ Promote health policy and system improvements at the local, state and national level,
- ❑ Continuously evaluate its programs and services for quality, value, and impact on the health of the community,
- ❑ Share our approaches, strategies, and results, and
- ❑ Oversee and maintain the agreements between Poudre Valley Health System, University of Colorado Health and the Health District on behalf of the community.

■ VALUES ■

- ❑ Dignity and respect for all people
- ❑ Emphasis on innovation, prevention and education
- ❑ Shared responsibility and focused collaborative action to improve health
- ❑ Information-driven and evidence-based decision making
- ❑ Fiscal responsibility/stewardship
- ❑ An informed community makes better decisions concerning health

SB21-199: REMOVE BARRIERS TO CERTAIN PUBLIC OPPORTUNITIES
Concerning measures to remove barriers to certain public opportunities.

Details

Bill Sponsors:	Senate – <i>Jaquez Lewis (D) and Winter (D)</i> , Gonzales (D), Bridges (D), Kolker (D), Pettersen (D) House – <i>Esgar (D) and Gonzales-Gutierrez (D)</i> , Amabile (D), Bacon (D), Caraveo (D), Herod (D), Hooton (D), Jodeh (D), Michaelson Jenet (D), Ricks (D), Titone (D), Woodrow (D)
Committee:	Senate State, Veterans, and Military Affairs
Bill History:	3/26/2021- Introduced in Senate
Next Action:	4/13/2021- Hearing in Senate State, Veterans, and Military Affairs

Bill Summary

Currently, both federal and state law require that individuals verify lawful presence to receive certain government benefits. This bill removes the requirement to verify lawful presence for state or local public benefits. Current law prohibits a state agency or political subdivision from entering into or renewing a public contract with a contractor who knowingly employs or contracts persons who are undocumented. The bill repeals that requirement and associated statutory provisions. Current law requires that state agencies and local governments use secure and verifiable identity documents when providing services or issuing official documents. The bill repeals that requirement.

Issue Summary

Federal Law: State & Local Public Benefits

Federal law has a variety of restrictions on benefits for undocumented immigrants. This section will focus on restrictions for state and local public benefits. Federal law states that undocumented immigrants are not eligible for any state or local public benefit¹, except in certain circumstances.² The exceptions include:

- Health care assistance necessary to treat an emergency medical condition, which means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.³ It cannot be related to an organ transplant procedure.
- Short-term non-cash, in-kind emergency disaster relief
- Immunization programs
- In-kind community services that protect life or safety (i.e. soup kitchens, crisis counseling, or short-term shelter) and are not conditional on income or resources

¹ 8 U.S. Code § 1621

² (A) any grant, contract, loan, professional license, or commercial license provided by an agency of a State or local government or by appropriated funds of a State or local government; and (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government.

³ 42 U.S. Code § 1396b(v)(3)

Federal law stipulates that lawful presence is not required for state or local public benefits created pursuant to state legislation that affirmatively provides that lawful presence is not required for eligibility.

State Law: Restriction of Public Benefits

Legislation originally passed in 2006, HB06S-1023, required state and local government agencies, with some exceptions, to verify the lawful presence of applicants for public benefits. Codified in Article 76.5 of Title 24 within the Colorado Revised Statutes, the exceptions currently include:

- Any purpose for which lawful presence is not required by law, ordinance, or rule
- Health benefits for treating an emergency medical condition,⁴ cannot be related to an organ transplant procedure
- Short-term, noncash, in-kind emergency disaster relief
- Immunization programs
- In-kind community services that protect life or safety (i.e. soup kitchens, crisis counseling, or short-term shelter) and are not conditional on income or resources
- Pregnant women
- Under the age of 18, including over 18 and under 19 years old and remain eligible for medical assistance after turning 18
- Renewing an educator license
- Recipients of certain higher education-related services and benefits

Immigrants in Colorado

According to the New American Economy, a bipartisan research and advocacy organization, there are around 145,000 undocumented immigrants living in Colorado as of 2019.⁵ The vast majority of these (89.9%) are of working age. Further, there are an estimated 9,806 undocumented entrepreneurs in the state. In 2019, undocumented immigrants in Colorado paid \$140.9 million in state and local taxes as well as \$231.7 million in federal taxes.⁶ Those individuals and families combined for approximately \$2.9 billion in spending power. Please note that these figures may differ from the ones included in the legislative declaration of the bill, as some of their numbers are from different sources or have been rounded.

Access to Health Care

Among the total nonelderly population in the United States, 45% of undocumented immigrants were uninsured, compared to about 23% of lawfully present immigrants and 8% of citizens, as of 2017.⁷ This high rate of uninsurance reflects the limited access to employer sponsored insurance as well as eligibility restrictions that prevent most from accessing Medicaid, Medicare, and the Affordable Care Act (ACA) marketplaces. Most undocumented adult individuals are only eligible for Emergency Medicaid.⁸ Emergency Medicaid only covers services for a 'life or limb threatening emergency' and labor and delivery for pregnant women. For those pregnant women, it does not cover any prenatal or postnatal care.

This Legislation**Legislative Declaration**

The General Assembly finds and declares the following statements. People who immigrated to the U.S. and live in Colorado are essential members of our communities. Every day, the state benefits from the contributions of undocumented immigrants to our society. Immigrants hold jobs that are critical to our economy and communities and in some industries comprise more than a third of the workforce. Immigrants

⁴ Same definition as the federal law

⁵ New American Economy (2021). *Colorado*. Retrieved from <https://www.newamericaneconomy.org/locations/colorado/>

⁶ New American Economy (2021). *Colorado*. Retrieved from <https://www.newamericaneconomy.org/locations/colorado/>

⁷ Kaiser Family Foundation (July, 15, 2019). Health Coverage and Care of Undocumented Immigrants. Retrieved from <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/>

⁸ 10 CCR 2505-10 8.100 section 8.1.00.3.G.1v

make the tourism industry run; build buildings; lay the roads; provide in-home care to seniors, children, and people with disabilities; bring food to our tables and doorsteps. Immigrants are over 9% of Colorado's population and contribute to the economy through the labor force, as consumers, and taxpayers. In 2019, all immigrants, regardless of documentation status, in Colorado paid almost \$6 billion in local, state, and federal taxes. In Colorado, undocumented immigrants pay nearly \$275 million in federal taxes and more than \$150 million in state and local taxes annually. These hardworking Coloradans are diverse and are often a part of a mixed-status family. In Colorado, the estimated population is 162,000, representing approximately 8% of children under 16 years of age. An estimated 276,589 Coloradans live with a family member who is undocumented, including 130,958 children. Children from immigrant families are disproportionately more likely to be from a low-income household.

The 2006 special legislative session facilitated the passage of anti-immigrant legislation that left behind immigrant families, citizen families experiencing homelessness, and persons fleeing domestic violence without necessary public benefits. These policies required state and local agencies to verify the lawful presence of applicants for public benefits, including professional, occupational, and commercial licenses. Undocumented immigrants who do not have the required documents to establish lawful presence prevents them from fully participating in Colorado's economy and accessing state and local public benefits, including loans, grants, contracts, food and housing assistance, energy assistance, and other benefits. Undocumented immigrants are ineligible for most federal benefits and were excluded from the stimulus money provided in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Local communities were restricted from providing their residents with crucial relief during the COVID-19 pandemic because of these anti-immigrant laws.

In 2018, various industries including child care, agriculture, health care, K-12 education, and transportation averaged between 1 to 2.5 job openings per every unemployed worker, demonstrating a high need for a larger labor pool. Protecting the wellbeing of these members of our communities and ensuring their access to important public benefits and opportunities, particularly during a global health crisis, makes our communities healthier, stronger, and more prosperous.

Therefore, the General Assembly declares it is the public policy of the state of Colorado that we ensure that our state-funded programs are not denied to people based on their immigration status.

Definitions

State or Local Public Benefits.⁹ Any grant, contract, loan, professional license, or commercial license provided by an agency of a State or local government or by appropriated funds of a State or local government; and any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government.

Lawful Presence Consideration

The bill repeals current law requiring the verification of lawful presence and replaces it with the following statement. Notwithstanding any law to the contrary and pursuant to federal law¹⁰, lawful presence is not a requirement of eligibility for state or local public benefits.

State & Local Public Benefit Funding

⁹ 8 U.S. Code § 1621

¹⁰ 8 U.S. Code § 1621 (d)

The General Assembly shall not allocate additional funding to any state or local public benefit program for purposes of not requiring lawful presence for fiscal year 2021-22. Starting in fiscal year 2022-23, any additional funding for a public benefit program is subject to the standard budgeting process. This section is repealed July 1, 2024.

Application for Licenses

The bill repeals the requirement for lawful presence to obtain a license issued by any division, board, or agency of the Department of Regulatory Agencies (DORA). The process now requires the applicant to produce one of the following documents:

- A valid Colorado driver's license or identification card or
- Any valid document, or combination of documents, that are sufficient to establish identity for the purpose of obtaining a driver's license or identification card

Business Licenses

The bill repeals the requirements for counties and municipalities to verify lawful presence to obtain a business or commercial license.

Identification Documents

The bill amends the current phrase that is included on Colorado driver's license or identification card that is issued to undocumented immigrants to read "Not valid for federal identification or voting purposes," it strikes the phrase "public benefit."

Public Contract Language

The bill repeals the article of statute that prohibits a state agency or political subdivision from entering into or renewing a public contract with a contractor who knowingly employs or contracts with individuals who are undocumented.

Secure and Verifiable Identity Documents

The bill repeals the article of statute that requires a public entity that provides services to not accept, rely upon, or utilize an identification document to provide services unless it is a secure and verifiable document.

Notary Applicants

The bill repeals the requirement that the Secretary of State verify the lawful presence of notary applicants through the process currently set in statute (which would be repealed by this bill), instead the Secretary will verify lawful presence by accepting one of the following documents:

- U.S. military card or a military dependent identification card
- U.S. Coast Guard Merchant Mariner card
- Native American tribal document
- Colorado driver's license or identification card, unless it is held by a person who is not a citizen of the state and who does not have permanent residency status

An affidavit needs to be executed that states that the applicant is a U.S. citizen or legal permanent resident or otherwise lawfully present in the U.S. pursuant to federal law.

Effective Date

The bill is effective as of July 1, 2021.

Reasons to Support

The 2006 laws placed strong restrictions at the state level on the availability of public opportunities and benefits for undocumented immigrants. They have led to a patchwork of state and local government policies that has created confusion and disparities around key resources, services, and information that threaten undocumented individuals' and families' ability to lead stable lives. The barriers to basic opportunities and services has been especially destructive in our current COVID and economic environment when individuals cannot access the extra supports that other individuals, families, and businesses are allowed to access. For children, barriers to public services, including quality child care, leads to poor health outcomes, increased learning gaps, and lower wages over a lifetime. Adults without documentation lack the wide variety of safety net services that are there for others in their community, creating a system of disadvantage. This bill would greatly diminish the restrictions, allowing all residents of Colorado an improved opportunity for stability, support, opportunity, and better health outcomes. The bill would allow individuals without documentation to access local and state public opportunities and benefits, although there will still be restrictions on federal benefits, giving Colorado the chance for lower poverty rates and healthier communities overall. It is likely that the bill would allow the Health District of Northern Larimer County to serve more individuals who have a clear need for health services that we provide, such as comprehensive dental care and mental health services.

Some would assert that although individuals may have come to the U.S. without legal status, they have become an integral part of the economic structure of the state and the fabric of our communities, and should be afforded the same opportunities as other Colorado residents.

In addition, the bill is likely to save time and money for state and local public benefit programs as there will be a decrease in the administrative burden of verifying lawful presence.

Supporters

- American Friends Service Committee, Colorado
- Bell Policy Center
- Boulder County
- Center for Health Progress
- City of Boulder
- City and County of Denver
- Coalition for Immigrant Health
- Colorado Center on Law & Policy
- Colorado Children's Campaign
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Statewide Parents Coalition
- Denver Human Services
- Early Childhood Council of Boulder County
- Early Childhood Council of Larimer County
- Good Business Colorado
- Healthy Child Care Colorado
- Hunger Free Colorado
- Illuminate Colorado
- Imagine!
- Immigrant & Refugee Center of Northern Colorado
- Immigrant Legal Center or Boulder County
- League of Women Voters of Colorado
- Mental Health Colorado
- Nourish Colorado
- Raise Colorado
- Small Business Majority
- Together Colorado
- Tri-County Health Network
- Voces Unidas

Reasons to Oppose

This bill could increase utilization of state and local programs, requiring increased staffing and resources, possibly creating or expanding waiting lists, and potentially necessitating future increased funding by both state and local governments.

Some may assert that individuals without documentation should not be allowed to access publicly-funded services.

Others may assert that this is an issue that is better addressed at the federal level.

Opponents

- Square State Strategy Group

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 analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

HB21-1150: CREATE THE COLORADO OFFICE OF NEW AMERICANS

Concerning the creation of the Colorado Office of New Americans.

Details

Bill Sponsors:	House – Jodeh (D) Senate – None
Committee:	House State, Civic, Military, & Veterans Affairs House Finance
Bill History:	3/3/2021- Introduced 4/8/2021- Hearing in House State, Civic, Military, & Veterans Affairs Committee
Next Action:	Hearing in House Finance Committee

Bill Summary

The bill creates the Colorado Office of New Americans (ONA). The ONA serves as the point of contact for immigrant-serving state agencies, private sector organizations, and the public about immigrant issues in Colorado. As its main priority, the ONA is required to implement a statewide strategy to facilitate economic stability and promote successful economic, social, linguistic, and cultural integration by investing in the success of immigrants in Colorado.

Issue Summary

Immigrants and Refugees¹

Lawfully present immigrants are noncitizens who are lawfully residing in the United States (U.S.). This group includes legal permanent residents (LPRs, i.e., “green card” holders), refugees, asylees, and other individuals who are authorized to live in the U.S. temporarily or permanently. Undocumented immigrants are foreign-born individuals residing in the U.S. without authorization. This latter group includes individuals who entered the country without authorization and individuals who entered the country lawfully and stayed after their visa or status expired.

Contextualizing Immigrants in the United States²

Immigrants are more likely to be active labor force participants than U.S.-born citizens - 83.0% of the country’s foreign-born population are between 16-64 years old, compared to just 64.3% of the U.S.-born population. This means that immigrants have a heavy presence in the U.S. economy, as workers, entrepreneurs, consumers, and taxpayers. Nationally, immigrants are more likely to hold an advanced degree than those born in the U.S., yet are simultaneously more likely to have less than a high school education. Thus, immigrants fill the workforces at both ends of the workforce skill spectrum - from science, technology, engineering, and math to agriculture, hospitality, and service industries. Immigrants are also filling the demand for health care jobs as millions of baby boomers age. Immigrants are twice as likely as the U.S.-born to work as home health aides, and also are twice as likely to be surgeons and doctors. Additionally, over recent decades, over 40 million immigrants have revitalized neighborhoods across the country, increasing housing wealth by \$3.7 trillion.

¹ Kaiser Family Foundation, “Health Coverage of Immigrants”, March 18, 2020. <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>

² New American Economy, “Immigrants and the Economy in Colorado”, 2021. <https://www.newamericaneconomy.org/locations/colorado/>

Contextualizing Immigrants in Colorado²

According to the New American Economy, a bipartisan research and advocacy organization, in 2019, Colorado had 537,334 immigrant residents, constituting 9.3% of the state's population. In addition, 43,684 of these immigrants were entrepreneurs. Colorado immigrant households earned a total of \$21.3 billion, paid \$5.8 billion in federal, state, and local taxes and had a spending power of \$15.6 billion in the same year. Immigrants also have a presence in the state's housing market, with 129,565 immigrants being homeowners. Foreign-born homeowners represent only 9.8% of recent homebuyers. The housing wealth held by these individuals and families amounted to \$56.6 billion, while immigrant-led families paid \$1.4 billion in rent. Please note that these figures may differ from the ones included in the legislative declaration of the bill, as some of their numbers are from different sources, different years, or have been rounded.

Colorado Refugee Services Program³

The Colorado Refugee Services Program (CRSP), housed within the Colorado Department of Human Services (DHS), aims to ensure the effective resettlement of refugees and to promote refugee advancement past self-sufficiency and to long-term integration. CRSP is responsible for the statewide coordination of refugee resettlement under the authority of the Refugee Act of 1980. The program and its network of contracts and partners focus on refugee resettlement, English as a second language, career pathway planning, health and wellness, youth services, and older adult services.

Immigration and Health Disparities

Health disparities are inequities in the quality of health, health care, and health outcomes experienced by groups based on social, racial, ethnic, economic, and environmental characteristics. Many factors contribute to health disparities, including genetics, access to care, quality of care, community features (e.g., inadequate access to healthy foods, poverty, limited personal support systems, and transportation), environmental conditions (e.g., poor air quality), language barriers, and health behaviors. These social, economic, and environmental conditions where people live, learn, work and play are known as social determinants of health.⁴ Health disparities account for significant costs to states and communities. According to a 2018 study by the W.K. Kellogg Foundation and Altarum, health disparities cost \$42 billion in lowered productivity and \$93 billion in excess medical costs each year.⁵ Additionally, those without access to health insurance and affordable care most often turn to emergency care, which is much more costly than primary care, preventative measures and care management.³

When immigrants and refugees first arrive to the United States, they face barriers to full economic, social, and political participation in their new communities. Some of these barriers minimize over time; however, full integration into the economic and social fabric takes time, often more than one generation. Second generation children of immigrants and refugees often narrow the gap significantly between their families and U.S. born non-hispanic whites, in terms of residential segregation, educational attainment, occupational status, wealth and home ownership. English-proficiency has virtually become a requirement for advancement in all such aspects of integration into U.S. communities.⁶

Extensive scientific research has revealed that anti-immigration policies and burdensome integration efforts restrict access to health services among the immigrant population and negatively effect mental health. Undocumented immigrants are more likely to screen positive for anxiety, depression, and post-traumatic stress disorder (PTSD), compared to documented immigrants and citizens. Such mental disorders are among

³ Colorado Department of Human Services, "Colorado Refugee Services Program", 2021. <https://cdhs.colorado.gov/crsp>

⁴ National Conference of State Legislatures, "Health Disparities Overview", November 16, 2020.

<https://www.ncsl.org/research/health/health-disparities-overview.aspx>

⁵ Altarum, "The Business Case for Racial Equity: A Strategy for Growth", April 24, 2018. <https://altarum.org/RacialEquity2018>

⁶ Migration Policy Institute, "Immigrants in the United States: How well are they integrating into society", May 2011.

<https://www.wilsoncenter.org/sites/default/files/media/documents/event/integration-Jimenez.pdf>

the leading causes of diminished productivity and impaired social functioning. Conversely, smooth integration into the U.S. and local communities is key for facilitating better health access and outcomes for immigrants.⁷

Cultural Barriers to Immigrant Health Insurance and Care Accessibility⁸

Language. About 30% of foreign-born U.S. residents do not speak English or do not know it well. Patients are less willing to seek medical care if they know they will have difficulty communicating their needs to health care professionals.

Differing Cultural Norms and Perceptions. The medical care system in the U.S., as well as its more complex sphere of managed care, is organized differently than many immigrants' home countries. Thus, immigrants are much less likely to have a primary care provider than native-born U.S. citizens. Additionally, immigrants may hold different views regarding the necessity and appropriateness of medical care, as well as of the role of mental health treatment.

Legal Status. Undocumented immigrants frequently worry that seeking medical care may expose their status and facilitate their deportation. Legally authorized immigrants also worry that using medical benefits may jeopardize their legal status and/or their ability to gain citizenship or permanent residency.

Legal and Regulatory Barriers to Immigrant Health Insurance and Care Accessibility

In the U.S., fewer than 1 in 10 citizens are uninsured, compared with 23% of lawfully present immigrants and more than four in ten (45%) undocumented immigrants. Coverage declines due to federal policy have important implications for the health and well-being of families and the financial stability of the health care system.⁹ The higher uninsured rate among noncitizens reflects limited access to employer-sponsored coverage; eligibility restrictions for Medicaid, the Children's Health Insurance Program (known as the Child Health Plan Plus [CHP+] in Colorado), and Affordable Care Act (ACA) Marketplace coverage; as well as barriers to enrollment in these programs and plans among eligible individuals.

Lawfully present immigrants may qualify for Medicaid and CHP+, but are subject to certain eligibility restrictions. In general, lawfully present immigrants must have a "qualified" immigration status to be eligible and most must wait five years before they may enroll. Some immigrants with qualified status, such as refugees and asylees, do not have to wait five years before enrolling. Some immigrants, such as those with temporary protected status, are lawfully present but do not have a qualified status and are not eligible to enroll in Medicaid or CHIP regardless of their length of time in the country. For children and pregnant women, states can eliminate the five-year wait and extend coverage to lawfully present immigrants without a qualified status. Over half of states have taken up this option for children and nearly half have elected the option for pregnant women.¹¹ Effective July 1, 2016, Colorado eliminated the five-year bar for all lawfully residing pregnant women and children in Colorado who qualify for Health FirstColorado (Colorado's Medicaid Program) or CHP+. ¹⁰ Lawfully present immigrants may be eligible for coverage through the ACA Marketplace, but limited language skills make it difficult to navigate options.¹¹

⁷ U.S. National Library of Medicine, "Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review", June 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4074451/>

⁸ Migration Policy Institute, "Health Care for Immigrant Families: Current Policies and Issues", June 2013. <https://www.migrationpolicy.org/sites/default/files/publications/COI-HealthCare.pdf>

⁹ Kaiser Family Foundation, "Health Coverage of Immigrants", March 18, 2020. <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>

¹⁰ Colorado Department of Health Care Policy and Financing, "Elimination of Five-Year Bar for Lawfully Residing Pregnant Women and Children", June 29, 2016. <https://www.colorado.gov/pacific/sites/default/files/Elimination%20of%20Five-Year%20Bar%20for%20Lawfully%20Residing%20Pregnant%20Women%20and%20Children.pdf>

¹¹ HealthCare.Gov, "Health Care Coverage for Immigrants", 2020. <https://www.healthcare.gov/immigrants/coverage/>

Undocumented immigrants are not eligible to buy Marketplace health coverage, or for premium tax credits and other savings on Marketplace plans.⁸ Most undocumented individuals in Colorado are only eligible for Emergency Medicaid.¹² Emergency Medicaid only covers services for a ‘life or limb threatening emergency’ and labor and delivery for pregnant women. For those pregnant women, it does not cover any prenatal or postnatal care. Documentation provided by a doctor regarding the emergency and a completed application is needed to apply for emergency coverage.¹³

Other State Efforts to Integrate Immigrants¹⁴

The California Legislature passed a law creating the position of Director of Immigrant Integration in the Governor’s office to coordinate immigrant services and monitor the implementation of immigration assistance programs. An Illinois resolution directed the Bilingual Advisory Task Force to investigate professional certification standards for foreign-language educational interpreters and help immigrant parents be more involved in their children’s education. Rhode Island directed a Senate task force to study evaluating and certifying foreign-trained professionals.

At least 27 states have passed legislation funding immigrant integration programs that teach English or advance biliteracy. Iowa’s Education Funding and Operations law, passed in 2017, includes funds to provide services including English and integration assistance to refugees. Washington state passed bipartisan legislation establishing the K-12 dual language grant program in the state’s public and state-tribal schools. The Washington law is designed to help students whose first language is not English achieve proficiency in both English and their native language. These programs allow immigrants to integrate into their local communities at a quicker pace.

This Legislation

Legislative Declaration

The bill finds and declares the numerical and economical significance of immigrants and refugees in Colorado, as well as their increasing propensity to become U.S. citizens.

- Immigrants and refugees constitute more than 10% of the Colorado population, or 500,000 individuals. Native-born Americans with at least 1 immigrant parent constitute over 11% of the Colorado population, or over 600,000 individuals.
- Immigrants and refugees are an important part of Colorado’s economy and taxbase.
 - Immigrant-led Colorado households paid 1.5 billion dollars in state and local taxes and infused over 14 billion dollars into the Colorado economy in 2018
 - Over 35,000 immigrant and refugee entrepreneurs employ more than 100,000 people
 - Immigrants and refugees have a large presence in Colorado’s economic sectors, making up:
 - Over 13% of Colorado’s science, technology, engineering and math workforce
 - 17% of the manufacturing workforce
 - 19% of the administrative & support, waste management, remediation services workforce
- Immigrants and refugees in Colorado are becoming U.S. citizens at an increasing rate
 - Colorado’s naturalization rate has increased 77% between 2017-2019
 - 113,873 Coloradans are currently eligible to naturalize.
- Integrating and including immigrants and refugees in Colorado communities will enrich the entire state.

¹² 10 CCR 2505-10 8.100 section 8.1.00.3.G.1v

¹³ Colorado Consumer Health Initiative, “Health Coverage Resources”, 2019. <https://cohealthinitiative.org/need-help/health-coverage-resources/>

¹⁴ National Conference of State Legislatures, “State Efforts to Help Immigrants Integrate”, December 2017. <https://www.ncsl.org/research/immigration/state-efforts-to-help-immigrants-integrate.aspx>

- The Colorado Office of New Americans (ONA) will be key to further this effort, as it will centralize the state programs, initiatives, and policies focused on integrating immigrants and facilitating their economic stability. The ONA will also hopefully grow to be able to give grants to local immigrant-focused, community-based organizations.
 - The ONA will be funded by gifts, grants, and donations through the 2022-2023 fiscal year but the ONA could also be funded by an appropriation before or during the 2022 regular legislative session

Definitions

Department: Colorado Department of Labor and Employment

Immigrant or New American: A person who has or will arrive to the United States as an immigrant or refugee, including their children. This includes refugees, asylees, special immigrant visa holders, victims of trafficking, Federal Deferred Action for Childhood Arrival Program recipients (DACA recipients), and all other immigrants and individuals hoping for U.S. citizenship, safety, or reunification with family.

Integration: A dynamic, two-way process in which immigrants and New Americans and their new communities collaborate to form safe, cohesive, and vibrant communities while also preserving cultural identities.

ONA: The Colorado Office of New Americans

Establishing the Colorado Office of New Americans

The Office of New Americans (ONA) will be created and housed within the Colorado Department of Labor and Employment (CDLE). The director of the ONA will be appointed by the Executive Director of CDLE. The ONA Director will have full capacity to work with the Office of the Governor and to convene other state agencies. The ONA Director will staff the ONA, considering applicants' personal and professional experiences within the immigrant community to make hiring decisions. The ONA is to convene stakeholders, CDLE, the Governor's office, the Department of Human Services (DHS), the Department of Regulatory Agencies (DORA), and the Department of Public Health and Environment (CDPHE) in order to develop a recommendation to the Governor's office on what state agencies or offices are best suited to administer the Colorado Refugee Services Program. The ONA shall complete draft recommendation by January 1, 2022 and provide the final recommendation to the Governor's office by one year after the effective date of this bill. The CDLE will report on the ONA and the recommendations during its annual SMART Act hearing.¹⁵ The legislative committee can make a recommendation that a legislator sponsor appropriate legislation regarding the Colorado Refugee Services Program.

The ONA's duties are as follows:

- Implement a statewide strategy to facilitate the economic stability of immigrants, as well as to promote their successful economic, social, linguistic, and cultural integration into Colorado.
- Field any and all immigrant-related issues/questions/concerns from immigrant-serving state agencies, private sector organizations and the public.
- Identify and address issues related to immigrant integration
- Foster enhanced inclusion for immigrants
- Ensure equitable opportunities and access to services for immigrants
- Establish and work with a community advisory committee that can provide input to the state from Colorado's immigrant communities.
- Work directly with immigrant populations to hear and address their concerns and obstacles in accessing services

¹⁵Enacted in 2010 and extensively revised in 2013, Colorado's SMART Government Act includes requirements for state departments to create publicly-available annual strategic/performance plans and present them to the General Assembly.

- Coordinate with the Colorado Refugee Services Program¹⁶ to align it with the goals of the ONA
- Manage or direct any other relevant programs that might exist or be created in the future, including immigrant-focused state programs, initiatives, and policies that might exist or be created in the future.
- Coordinate with and make recommendations to the Governor, the General Assembly and state agencies on ways to improve policies and programs to support immigrant integration across the state, such as
 - Recommending changes in the organization, management, programs and budget of state agencies
 - Coordinating with state agencies and public-private partnerships
 - Serving as a resource for community-based organizations that serve immigrants
 - Creating a private-public program to build-up immigrant-serving nonprofits statewide
 - Recommending and participating in cultural competency and diversity, equity and inclusion training for state departments
- Use state and federal data to inform the state's efforts to advance the economic stability and integration for immigrants. Data will never be used or shared solely for civil immigration enforcement
- Advise the Governor, state agencies, and the General Assembly on any immigrant issue
- When sufficient funds are available the ONA shall:
 - Sponsor studies, symposia, research, and factual reports to gain and share insight with the Governor, state agencies, and General Assembly on issues concerning immigrants in Colorado.
 - Analyze economic and demographic trends to make policy and programmatic trends to the Governor, state agencies, and the General Assembly.
 - Ensure that ONA's system, vital documents, and communications are accessible to all Coloradans, regardless of English proficiency or disabilities. This includes ensuring ONA exceeds compliance to the Americans with Disabilities Act of 1990¹⁷ and the Colorado Anti-Discrimination Act¹⁸
 - Promote integration activities among immigrants, using a model similar to the Family Resource Center Program, with the goal of implementing immigrant support through community-based initiatives and nonprofit organizations where immigrants and immigrant families can access formal and informal support to promote their health, economic well-being, and integration. Including:
 - *Economic opportunities*: workforce development, entrepreneurship and higher education, naturalization
 - *Increased access*: connecting immigrants to local, state, and federal resources, English language learning programs, referrals to community-based programs
 - *State education and outreach*: promoting and celebrating immigrants' successes and contributions to Colorado

By November 1, 2022, and every year thereafter, ONA's Director, or their designee, will submit a yearly report to the General Assembly regarding the ONA's activities, information, and programmatic data. To minimize costs, the ONA is allowed to incorporate or append this report to any other reports it must develop.

Funding of the ONA

The Colorado General Assembly may appropriate money from the General Fund, or any other available source, for the ONA. The ONA may also seek, accept and expend grants, gifts or donations.

ONA within CDLE

The bill adds the ONA, the ONA director, and ONA functions as a division or program operate under CDLE.

¹⁶ Established by C.R.S. § 26-2-138

¹⁷ 42 U.S.C. § 12102. <https://www.law.cornell.edu/uscode/text/42/12101>

¹⁸ C.R.S. § 24-34-601 et al.

Refugee Services Program

The bill requires the program to assist the ONA with carrying out its duties and goals, including the sharing of outcomes, partnerships, and alignment of mission and purpose

Effective Date

The bill, subject to a petition, takes effect at 12:01am on the day following the expiration of the 90 day period after the final adjournment of the General Assembly.

Reasons to Support

This bill creates administrative efficiency, and will likely decrease redundancy, as it organizes and coordinates all immigrant support and integration efforts within one entity. Thus, an Office of New Americans will help service agencies better serve their client population. The ONA would improve the ability of refugees and immigrants to integrate smoothly and more successfully into Colorado. Such coordination of services for immigrant integration will facilitate better health outcomes for the immigrant communities across the state by aiding in addressing factors related to health care social determinants of health.

The immigrant population faces unique, complex challenges as well as extra barriers, but with targeted assistance, they may have equitable opportunity for contributing to the economic strength of the state and promoting healthy families and communities.

Supporters

- City of Aurora
- Colorado Coalition for the Homeless
- Colorado Immigrant Rights Coalition
- FWD.us
- International Rescue Committee
- JEWISHcolorado
- World Education Services

Reasons to Oppose

This bill may create additional strain on state finances and potentially adds administrative burden on the Colorado Department of Labor and Employment. Immigrant and refugee integration may be considered a personal and community-level responsibility, rather than an appropriate task for state government. Additionally, the ONA's extensive list of responsibilities may overextend the availability of funds and staffing. Some may assert that there are other populations in need of assistance to facilitate economic stability, and assistance for those individuals should be prioritized.

Opponents

- No opposition has been made public at this time.

Other Considerations

One consideration is whether it make sense to put the ONA in a separate department from the Colorado Refugee Services Program, as the separation of agencies could erect barriers to make it more difficult to maximize coordination of approaches and services.

Organizations Monitoring the Bill

- Colorado Farm Bureau

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 analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

HB21-1232: STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION

Concerning the establishment of a standardized health benefit plan to be offered in Colorado.

Details

Bill Sponsors:	House – Roberts (D) & Jodeh (D), Mullica (D), Amabile (D), Bernett (D), Caraveo (D), Cutter (D), Duran (D), Gonzales-Gutierrez (D), Hooton (D), Kennedy (D), Kipp (D), McCluskie (D), McCormick (D), Ortiz (D), Ricks (D), Sirota (D), Tipper (D), Valdez A. (D), Weissman (D), Woodrow (D) Senate – Donovan (D), Bridges (D), Danielson (D), Gonzales (D), Jacquez Lewis (D), Pettersen (D), Story (D), Winter (D)
Committee:	House Health & Insurance
Bill History:	3/18/2021- Introduced in House
Next Action:	4/9/2021- Hearing in House Health & Insurance Committee
Fiscal Note:	3/29/2021

Bill Summary

The Colorado Health Insurance Option is a two-phased approach aimed at addressing the affordability of health insurance in Colorado. Phase One includes the creation of a standardized insurance plan by the Division of Insurance (DOI) for carriers to offer in areas where they currently offer plans in both the individual and small group markets. The bill encourages insurance carriers to work with other groups of the health care industry (i.e. hospitals, prescription drug manufacturers, providers) to reduce their insurance premiums by 10 percent each year over two years. If the cost reduction targets are not met, Phase Two is triggered, and the State of Colorado will offer the standardized plan on individual and small group markets through the newly established Colorado Option Authority, a quasi-governmental entity.

The Commissioner of Insurance is required to apply to the secretary of the United States Department of Health and Human Services for a waiver and include a request for a pass-through of federal funding to capture savings as a result of the implementation of the standardized plan.

If the U.S. Congress establishes a national public option program that meets or exceeds requirements in this bill, the bill and program is repealed.

Issue Summary

Affordable Care Act (ACA)

Signed into federal law in 2010, the Patient Protection and Affordable Care Act (ACA) expanded access to health insurance in the United States. Specifically, the ACA allowed for the expansion of Medicaid to all previously non-Medicare eligible individuals under age 65 with incomes up to 133% of the Federal Poverty Level (FPL). The legislation also codified four pillars of protections for people: guaranteed issue, adjusted community rating, prohibition against preexisting condition exclusions, and essential health benefits.¹ Under

¹ Kaiser Family Foundation (KFF) (Apr. 25, 2013). *Summary of the Affordable Care Act*. Retrieved from <https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

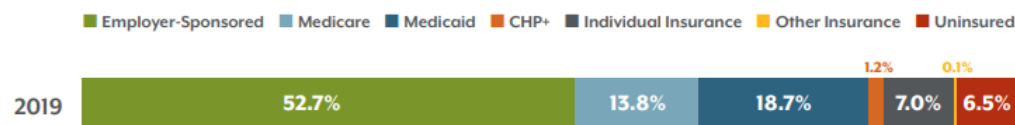
the essential health benefits, certain preventive and wellness services must be covered without imposing any cost-sharing on the patients receiving those services.^{2,3}

The ACA requires plans in both the individual and small group market to cover essential health benefits (EHB). This includes items and services in the following benefit categories:

- | | |
|--|--|
| 1. Ambulatory patient services | 7. Rehabilitative and habilitative services and devices |
| 2. Emergency services | 8. Laboratory services |
| 3. Hospitalization | 9. Preventive and wellness services and chronic disease management |
| 4. Maternity & newborn care | 10. Pediatric services, including oral and vision care |
| 5. Mental health and substance use disorder services including behavioral health treatment | |
| 6. Prescription drugs | |

Insurance Coverage in Colorado

Coloradans can get health insurance coverage through a variety of different means, depending on eligibility. There are public programs, such as Medicare, Medicaid, and Child Health Plan Plus (CHP+), or private insurance through an employer, through the marketplace run by Connect for Health Colorado, or insurance that is offered off the marketplace. This figure from the Colorado Health Institute (CHI) demonstrates the proportion of residents in the different types of insurance coverage offered in Colorado.⁴



According to the 2019 Colorado Health Access Survey (CHAS) from CHI, 93.5% of Coloradans are insured.¹ For those who reported being uninsured in the 2019 CHAS, 89.6% cited that the cost of the insurance was a barrier to purchasing coverage, which is much greater than the 78.4% that had the same response in 2017.¹

Each of the 64 counties in Colorado has at least one carrier providing insurance on the marketplace. For the 2021 plan year, 10 of Colorado's 64 counties had only one carrier offering plans, a decrease from 22 counties for the 2020 plan year.⁵

Health insurance plans on the individual market were nearly 50 percent more expensive in 2019 than in 2014.⁶ For employer sponsored insurance, the average annual family premium in 2019 totaled \$20,171, including both the employer and employee contribution.⁷ In comparison, the average annual family premium for employer sponsored insurance totaled \$16,940 in 2015.

After falling from 12% to 4% between 2013 and 2016, in 2019, 8% of Larimer County survey respondents ages 18 to 64 reported having no health insurance. In 2019, 18% of respondents age 18-64 from lower

² HealthCare.gov (n.d.) *Preventive Health Services*. Retrieved from <https://www.healthcare.gov/coverage/preventive-care-benefits/>

³ KFF (n.d.) *Preventive Services Covered by Private Health Plans under the Affordable Care Act*. Retrieved from <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>

⁴ Colorado Health Institute (CHI) (Jan. 2020). *Progress in Peril: 2019 Colorado Health Access Survey Storybook*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf

⁵ Division of Insurance (July 9, 2020). *Same eight companies returning to offer individual health insurance plans 2021 while number of plans increases*. Retrieved from <https://doi.colorado.gov/press-release/same-eight-companies-returning-to-offer-individual-health-insurance-plans-for-2021>

⁶ CHI (March 2020). *ACA at 10 Years: Consumer Costs*. Retrieved from <https://www.coloradohealthinstitute.org/research/aca-10-years-consumer-costs>

⁷ KFF (2020) *Health Costs and Budget Indicators*. Retrieved from <https://www.kff.org/state-category/health-costs-budgets/employer-based-health-insurance-premiums/>

income households (<185% FPL) reported being uninsured.⁸ Further, respondents ages 18-64 in 2019 that identified as Hispanic had significantly higher rate of uninsurance(17.0%) than White non-Hispanic individuals (7.1%). In 2019, 53.8% of Larimer County adults reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.

Health Care Costs in Colorado

Colorado's health care system currently ranks sixth in the nation according to the Commonwealth Fund.⁹ However, Colorado still struggles to increase access to health care and improve affordability, ranking 24th in the U.S. The report found that Colorado had low marks in adults without a usual source of care, alcohol deaths, and suicide deaths. Coloradans continue to have strong concerns about the cost of health insurance and care, and people in Colorado can have dire financial circumstances if they develop chronic illness or have emergency or other needs for health care that result in high out-of-pocket costs. Coloradans spend an average of \$6,804 per capita (14 percent of their income) on health care, and costs can be far higher for many.¹⁰ Analysis shows that costs will continue to rise and manifest in increased deductibles, with nearly all insurance plans in Colorado relying on deductibles to cover costs. A few of the reasons that the cost of care continues to rise include expensive technologies, consolidation, fee-for-service payments, prescription drugs, low-value care, and the continued aging of the population.¹¹ Currently, some say that health care costs are rising unsustainably, making the availability of affordable health care a concern for many Coloradans.¹²

A 2018 report from the Network of Regional Healthcare Improvement (NRHI) demonstrates how Colorado compares to five other states, which were chosen as part of a pilot, for health care costs of those individuals that are commercially insured.¹³ Colorado's risk-adjusted total cost per person in 2016 was 19% higher than the six-state average. Further analysis of the data by the Center for Improving Value in Health Care (CIVHC) found that Colorado has higher than average prices across all of the service categories, and was the only state of the six to have higher prices than average for these groups.¹⁴ These higher than average prices for inpatient (31%), outpatient (15%), professional (7%) and pharmacy (5%) were found to be the main drivers of the higher total average spend per person. The utilization and price of these services also vary in different areas of the state.

A report from the Colorado Health Institute (CHI) and Colorado Hospital Association (CHA) found that 75% of the total spending by health service category in the state goes to hospitals (34%), physician, professional, and clinical services (29%), and insurance administrative costs (12%).¹⁵ The remainder goes to nursing home/home health/other residential and personal care (10%), retail drugs (7%), medical equipment (3%), and other (5%).

⁸ Health District of Northern Larimer County (2020). *2019 Community Health Assessment*. Retrieved from <https://www.healthdistrict.org/2019-community-health-assessment>

⁹ The Commonwealth Fund. (2020). "2020 Scorecard on State Health System Performance." Retrieved from <https://www.commonwealthfund.org/publications/scorecard/2020/sep/2020-scorecard-state-health-system-performance>

¹⁰ CHI. (Dec. 14, 2018). *Affordability in Colorado: Questions and Answers about Health Care Costs*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf.

¹¹ CHI. (2017). *A Fresh Look at Health Care Cost Drivers: Exploring Free Market and Regulatory Solutions*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/X_Cost_Drivers_fact_sheet_SENT.pdf

¹² Colorado Consumer Health Initiative (Feb. 2019). *What Coloradans Are Saying About Health Care*. Retrieved from <https://www.cohealthinitiative.org/what-coloradans-are-saying-about-health-care>

¹³ NRHI (Nov. 8, 2018). *Healthcare Affordability: Data is the Spark, Collaboration is the Fuel*. Retrieved from http://www.nrhi.org/uploads/rwj_tcoc_phaseiii_benchmark_2018_r7.pdf

¹⁴ CIVHC (Nov. 8, 2018). *Colorado's Health Care Costs Continue to Rise Above Other States*. Retrieved from <https://www.civhc.org/2018/11/08/colorados-health-care-costs-continue-to-rise-above-other-states/>

¹⁵ CHI (2018). *Affordability in Colorado: Answers about Health Care Costs*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf

Colorado Health Insurance Affordability Enterprise

The Health Insurance Affordability Enterprise was established in Colorado with the passage of SB20-215.¹⁶ It is designed to address the affordability of health insurance on the individual market and to expand subsidies for those not eligible for federal subsidies under the ACA. The enterprise administers a health insurance affordability fee assessed on health insurers and hospitals to fund measures to reduce consumer costs for individual health coverage plans. The enterprise is governed by an 11 person board.¹⁷

1332 Waiver

Within the Affordable Care Act (ACA), section 1332 allows for states to implement elements of the ACA in alternative manners. Section 1332 waivers are limited as these novel approaches must be as successful in providing affordable, quality health coverage and cost the federal government either the same amount or less than the standard implementation. There are four specific limitations for this waiver, known colloquially as “guardrails.” The innovation must:

1. Provide coverage that is the same or more comprehensive than the original;
2. Provide coverage that is at least as affordable;
3. Provide coverage for the same amount or more people; and
4. Not add to the federal deficit.

These guardrails were set forth in the statutory language, but can be interpreted differently by each administration. The Centers for Medicare and Medicaid Services (CMS) has created detailed guidance, which leads states through the 1332 waiver process, which was updated in October 2018 by the Trump Administration.¹⁸ The new guidance outlined that waiver applications that incorporate one or all of the dictated principles that are preferred by the agency:

1. Provide increased access to affordable private market coverage over public programs, and increase insurer participation and promote competition;
2. Encourage sustainable spending growth by promoting more cost-effective coverage, restraining growth in federal spending, and eliminating state regulations that limit market choice and competition;
3. Foster state innovation;
4. Support and empower those in need; and
5. Promote consumer-driven health care.

The new guidance largely maintains the 2015 guidance’s approach to budget neutrality.¹⁹ However, a sentence was removed that stated that a waiver application that increases the deficit in any given year may not meet the deficit neutrality requirement. This suggests that a waiver could increase the federal deficit during the waiver’s effect and still be approved (so long as the overall waiver does not increase the federal deficit).

It is yet to be seen how the Biden Administration will likely change the 1332 waiver guidance that was updated by the Trump Administration.

¹⁶ <https://leg.colorado.gov/bills/sb20-215>

¹⁷ Division of Insurance (2021). *Health Insurance Affordability Enterprise*. Retrieved from <https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-legislation/health-insurance-affordability>

¹⁸ The Centers for Medicare and Medicaid Services [CMS]. (2018) *State Relief and Empowerment Waivers*. Retrieved from <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf>

¹⁹ Keith, K. (Oct. 23, 2018). Feds Dramatically Relax Section 1332 Waiver Guardrails. *Health Affairs Blog*. DOI:

10.1377/hblog20181023.512033. Retrieved from

<https://www.healthaffairs.org/doi/10.1377/hblog20181023.512033/full/#:~:text=Section%201332%20allows%20states%2C%20with,the%20goals%20of%20the%20ACA>.

Federal Legislation

United States Senators Michael Bennet (D-CO) and Tim Kaine (D-VA) introduced S. 386, “Medicare-X Choice Act of 2021”²⁰ on February 23, 2021, with a companion bill in the House (H.R. 1227²¹) sponsored by Representative Antonio Delgado (D-NY).²² The bill would create a federal public option (“Medicare-X”) available on the individual and small group markets. Medicare-X would use the existing Medicare program’s network of providers, guarantee the essential health benefits of the ACA, and prescription drug costs would be negotiated in conjunction with the Medicare Part D program. Enhanced marketplace subsidies would help finance the program for all participants. Medicare-X would still retain other current sources of private and public health insurance coverage.

H.R. 1976, “To establish an improved Medicare for All national health insurance program,” was recently introduced by Representative Pramila Jayapal (D-WA), along with 112 other cosponsors, including Colorado Representatives Diana DeGette (D), Joe Neguse (D), and Ed Perlmutter (D).²³ Medicare-for-All would serve as a single federal program with comprehensive benefits for all US residents. It would be tax-financed and require no premiums or cost sharing. Medicare for All would replace all private insurance, Medicaid, Medicare, and the Children’s Health Insurance Plan (known as CHP+ in Colorado) for covered benefits. This would include primary care, vision, dental, prescription drugs, mental health, substance use disorder, long-term services and supports, reproductive health care, and other services.

This Legislation

Legislative Declaration

The General Assembly, exercising its powers, finds the following. Health insurance coverage has a positive impact on people’s health outcomes as well as their financial security and well-being. Ensuring access to affordable, quality, continuous, and equitable health care is a challenge that officials and experts have faced for decades despite seemingly constant efforts to address the issue. Great strides have been made in increasing access to health care coverage through federal and state legislation. However, not enough has been accomplished to address the affordability of health insurance in Colorado, particularly in the state’s rural areas and for groups historically and systematically disinvested in public policy including people of color and undocumented Coloradans. The health care system is a complex system wherein consumers rely on insurance carriers to negotiate the rates paid to providers, pharmaceutical companies, and hospitals for services provided to consumers and expect that the negotiated rates are closely tied to the amount of the insurance premiums paid by consumers. Despite efforts to address access to and affordability of health care, underlying health care costs continue to rise, thus driving up the costs of premiums, often at disproportionate rates in rural areas of the state. In order to ensure that health insurance is affordable, it is critical that Colorado establishes a standardized plan for carriers to offer in the state and to set premium targets for carriers to achieve. If carriers cannot offer the standardized plan at the premium targets, a quasi-governmental entity is needed to offer the Colorado option, an affordable option for the purpose of increasing equitable access to and availability of statewide affordable, quality health insurance in the small group market and to any resident seeking coverage in the individual market.

Definitions

Advisory Committee. The Colorado option advisory committee.

Authority. The Colorado option authority.

²⁰ As of February 23, 2021, Senator Michael Bennet (D-CO) is a cosponsor.

²¹ As of March 18, 2021, Representative Ed Perlmutter (D-CO) is a cosponsor.

²² Congress (March 23, 2021). *S. 386- Medicare-X Choice Act of 2021*. Retrieved from [https://www.congress.gov/bill/117th-congress/senate-bill/386/cosponsors?q={%22search%22:\[%22medicare+x%22\]}&r=2&s=1&searchResultViewType=expanded](https://www.congress.gov/bill/117th-congress/senate-bill/386/cosponsors?q={%22search%22:[%22medicare+x%22]}&r=2&s=1&searchResultViewType=expanded)

²³ Congress (March 23, 2021). *H.R. 1976- To establish an improved Medicare for All national health insurance program*. Retrieved from <https://www.congress.gov/bill/117th-congress/house-bill/1976/cosponsors?r=1&s=3&q=%7B%22search%22%3A%5B%22medicare+for+all%22%5D%2C%22cosponsor-state%22%3A%22Colorado%22%7D>

Board. The Colorado option authority board.

Colorado Option. The standardized plan offered by the authority.

Health Care Coverage Cooperative. A health care coverage cooperative created as an entity that provides to its members health coverage and health care purchasing services, including but not limited to detailed information on comparative prices, usage, outcomes, quality, and member satisfaction with provider networks.²⁴

Health Care Provider. A health care professional who is registered, certified, or licensed under Title 12²⁵ or a health facility licensed under Title 25.²⁶

Small Group Market. The market for small group sickness and accident insurance.

Standardized Plan. The standardized health benefit plan designed by rule of the Commissioner of Insurance.

PHASE ONE

Establishing Standardized Health Plan

By January 1, 2022, the Commissioner will establish a standardized health plan to be offered by carriers in the individual and small group markets. The standardized plan must:

- Offer health care coverage at the bronze, silver, and gold levels
- Include, at a minimum, all essential health benefits
- Be offered through Connect for Health Colorado and through the Public Benefit Corporation (to be established)
- Be a standardized benefit design that:
 - Is created through a stakeholder engagement process, including health care industry, consumer representatives, and individuals working in or representing communities that are diverse (race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic regions of the state or are affected by higher rates of health disparities and inequities)
 - Has defined benefit design and cost sharing and
 - Is designed to improve racial health disparities, through a variety of means, including the improvement of perinatal health care coverage
- Provide first-dollar, pre-deductible coverage for certain high-value services identified collaboratively with consumer stakeholders, which reduce racial disparities in health outcomes, such as primary care and behavioral health
- Comply with the ACA and the requirements under this new Article 16 under Title 10

The standardized plan must be offered in a way that allows consumers to compare the standardized plans offered by different carriers. The Commissioner can update the standardized plan annually, by rule through the aforementioned stakeholder process.

Standardized Health Plan- Carrier Requirements

Starting January 1, 2023, and every year after, a carrier that offers an individual plan in Colorado is encouraged to offer the standardized plan in the market in each zip code where they offer an individual plan.

²⁴ Definition from C.R.S. § 10-16-1002(2)

²⁵ This includes the following professionals: acupuncturists, athletic trainers, audiologists, chiropractors, dentists, dental hygienists, direct-entry midwives, hearing aid providers, massage therapists, physicians, physician assistants, psychologists, social workers, marriage and family therapists, licensed professional counselors, unlicensed psychotherapists, addiction counselors, naturopathic doctors, nurses, nurse aides, nursing home administrators, occupational therapists, occupational therapy assistants, optometrists, pharmacists, physical therapists, physical therapy assistants, podiatrists, psychiatric technicians, respiratory therapists, speech-language pathologists, surgical assistants, surgical technologists, and veterinarians.

²⁶ Specifically, licensed pursuant to C.R.S. § 25-1.5-103. This includes: general hospitals, freestanding emergency departments, psychiatric hospitals, community clinics, rehabilitation hospitals, convalescent centers, community mental health centers, acute treatment units, behavioral health entities, facilities for persons with intellectual and developmental disabilities, nursing care facilities, hospice care, assisted living residences, dialysis treatment clinics, ambulatory surgical centers, birthing centers, home care agencies, and other facilities of a like nature

Similarly, a carrier offering a small group plan is encouraged to offer the standardized plan in the market in each zip code where it currently offers a small group plan.

In the individual and small group market beginning plan year 2023, each carrier offering a standardized plan is to set a goal of offering the plan at a premium rate that is at least 10% less than the premium rate for plans offered by the carrier in that county in 2021. The Commissioner must calculate the rate reduction based on the rates charged in the same county, prior to the application of the reinsurance program. For a carrier offering the standardized plan in a county where it did not offer a plan in the individual or small group market in 2021, the carrier shall set a goal of offering the standardized plan with a premium that is at least 10% less than the average premium rate for plans offered in that county in 2021, calculated based on the average premium prior to applying the reinsurance program. The average premium is based on the county's individual market for individual plans and small group market for small group plans.

For plan year 2024, the carriers offering a standardized plans are to set a goal to reduce premiums at least 20% in comparison to 2021. The aforementioned reduction calculations and stipulations for plan year 2023 would be applied in plan year 2024.

For plan year 2025, and each year after, each carrier and health care cooperative is encouraged to limit annual premium rate increases for the standardize plan in both markets by a rate that is no more than the consumer price index for all urban consumers plus one percent, in comparison to the previous year.

The premium rate reductions in plan years 2023 and 2024 must account for policy adjustments deemed necessary to prevent people with low and moderate income from experiencing net increases in premium costs.

PHASE TWO

Creation of Colorado Option Authority

The Colorado Option Authority is created as a nonprofit, unincorporated public entity. The implementation and operation of the Authority is contingent on receiving a federal waiver and receiving the correlated federal funds. The Authority is to operate as a health insurance carrier in Colorado to offer the Colorado Option on the individual and small group market, if an independent actuarial analysis demonstrates that carriers failed to meet the premium rate reduction goals. The rate reduction goals are to be adjusted for changes in the standardized plan based on plan coverage requirement changes imposed by state or federal law. The actuarial analysis must take into account any coverage requirement changes. The Commissioner shall establish, through rulemaking, the requirements for the methods to calculate the rate reductions. If it is determined that carriers failed to meet the premium rate reductions, the Commissioner notifies the Governor and the Board that the Authority is required to offer the Colorado Option.

The Authority is an instrumentality of the state, except that its debts and liabilities do not constitute the debts and liabilities of the state. The Authority is not an agency of the state, not a district for the purposes of the Taxpayer's Bill of Rights (TABOR),²⁷ and is not authorized to promulgate rules. The Authority implements the provider reimbursement fee schedule for services covered by the Colorado Option.

The Colorado Option Authority Board is created with 9 members appointed by the Governor and confirmed by the Senate. The Board is the Authority's governing body and shall determine its development, governance, and operation. The Board is not an agency of the state. In making Board appointments, the Governor shall appoint individuals who have experience or expertise in at least two of the following areas:

- Individual health insurance coverage

²⁷ Section 20 of Article X of the Colorado Constitution

- Value-based purchasing and plan design
- Health care consumer navigation and assistance in accessing health care
- Health care finance
- Provision of health care services in rural areas
- Provision of health care services to uninsured and low-income populations
- Health care actuarial analysis
- Member of an employee organization that represents employees in the health care industry
- Health care delivery systems
- Representing consumers in the development of health care policy
- Hospital administration
- Insurance brokerage
- Improving health equity for communities of color and decreasing racial disparities in health care

The Governor must ensure that the Board's membership as a whole has demonstrated experience and expertise in most of the listed categories. At least 5 members of the Board must be consumers, representatives of consumers, and small business owners. One member must represent hospitals. One member must represent providers. To the extent possible, the Governor shall appoint members who reflect the diversity of the state with regards to race, ethnicity, immigration status, income, wealth, ability, and geography. A person employed by a carrier or managed care organization is not eligible for appointment.

The Governor shall appoint 5 members to an initial term of 4 years and 4 members to an initial term of 2 years. After those initial terms, all terms are for 4 years. Each member may serve no more than 2 full, 4 year terms. Members who are appointed to an initial 2 year term can serve up to 2 additional 4 year terms after their initial term. The members serve at the pleasure of the Governor. The Governor can fill any vacancies.

Members must publicly disclose whether they have any financial interest in the implementation of the Colorado Option. Members may receive a per diem for their service and may be reimbursed for actual and necessary expenses, including any required dependent care, dependent or attendant travel, food, and lodging while engaged in performing their official duties.

The Board and its members are subject to the state's Open Meetings Law²⁸ and Colorado Open Records Act.²⁹ Additionally, it is not required to comply with the state procurement code and is not subject to or part of the state personnel system. The Board must hire an Executive Director of the Authority, seek and maintain the ability to operate as a carrier in Colorado, consult with and consider recommendations from the advisory committee, not duplicate or replace the powers and duties of the Commissioner of Insurance, and may contract with state agencies to implement the Colorado Option.

Provider Fee Schedule

The Commissioner must promulgate rules to establish a reasonable reimbursement fee schedule for health care services that are covered by the Colorado Option. The Commissioner is to consult with the Executive Director of the Department of Health Care Policy and Financing (HCPF) to inform providers concerning the proposed fee schedule. The fee schedule is to be made available to the Authority to enable it to set premium rates. The premium rates are subject to review and approval pursuant to the typical rate filing process.

In establishing the fee schedule, the circumstances of critical access hospitals, rural and independent providers, and providers that serve a high percentage of uninsured and Medicaid patients may be taken into account. The Commissioner may also take into account the cost of adequate wages, benefits, staffing, and training to provide adequate care. The fee schedule must:

²⁸ Part 4, Article 6, Title 24 of the Colorado Revised Statutes

²⁹ Part 2, Article 72, Title 24 of the Colorado Revised Statutes

- Apply to hospitals, health care providers, pharmacies, and all other providers delivering health care services in Colorado, which are covered by the Colorado Option
- Set the reimbursement fees for 2025 to achieve at least a 20% decrease in premiums when compared to rates for health plans offered in the individual and small group markets in 2021
- Set reimbursement fees for 2026 and each year after at rates that ensure the premiums do not increase by more than the Consumer Price Index (CPI) for all urban consumers³⁰ plus 1%, relative to the previous year, and
- Be available to other plans, as determined by the Commissioner, including health coverage cooperatives, if members of the cooperative opt to be subject to the regulatory authority of the Commissioner

Each health care provider shall accept patients enrolled in any Colorado Option plan. The exception is that the Commissioner, in consultation with HCPF and the Authority Board, can exempt a particular provider, hospital, or pharmacy from the fee schedule or change the fee schedule for that entity upon a demonstration that the fee schedule will reduce their ability to accept or provide health care services to patients who are uninsured or enrolled in Medicaid or the Children's Health Plan Plus (CHP+). A provider cannot balance bill Colorado Option enrollees and shall accept the fee for the service provided to the consumer.

When implementing the hospital reimbursement rate formula, the Commissioner and the Authority Board are to consult with employee membership organizations representing health care providers' employees and with hospital-based providers. Changes can be made by rule to the hospital reimbursement rate formula so that reimbursement rates reflect the cost of adequate wages, benefits, staffing, and training for these employees to provide quality care.

Colorado Option Authority Advisory Committee

The Authority's Board is to appoint an advisory committee to make recommendations to the Board and the Authority concerning the development, implementation, an operation of the Authority and the Colorado Option. In its recommendations, the advisory committee shall give special consideration to those with low incomes and to communities of color. The Board determines the terms for the members of the advisory committee and must ensure that they represent the diversity of the state, including members who intend to enroll in the Colorado Option.

Federal Waiver

On and after the effective date of the bill, the Commissioner can apply to the Secretary of the U.S. Department of Health and Human Services for a Section 1332 waiver. Upon approval of the waiver, the Commissioner can use any federal funds that are derived from the waiver to establish the Authority and for the Colorado Health Insurance Affordability Enterprise to increase the value, affordability, quality, and equity of health care coverage. The implementation and operation of the Authority is contingent upon approval of the 1332 waiver and receiving the related federal funds.

Rules

The Commissioner can promulgate rules that are necessary to develop, implement, and operate both phase one and phase two of the bill.

Severability

If any provision of phase one or two of the Colorado Option is judged invalid, it does not affect the provisions that can continue to occur without the invalid provision.

³⁰ The 12-month CPI from February 2020-February 2021 is 1.7%. More information on the CPI can be found here: <https://www.bls.gov/cpi/>

Repeal on Enactment of National Public Option

The bill is repealed if the U.S. Congress enacts and the President signs a national public option program that meets or exceeds the premium reduction goals and coverages the populations that will receive coverage under the Colorado Option. The exception to the repeal includes the definitions of “small group market” and “standardized plan”, the establishment of a standardized health benefit plan, and the requirement for carriers to provide the standardized health benefit plans.

Rate Filing

The bill adds a provision to the reasons why the Commissioner shall disapprove of requested rate increase. If the rate filing reflects a cost shift between the standardized plan and the plan for which rate approval is being sought, the rate increase shall be disapproved. The Commissioner may consider the total cost of health care when making this determination.

Health Insurance Affordability Cash Fund

The bill allows for money to be allocated to the fund pursuant to the funds received under the 1332 waiver. Also, the fund consists of all interest and income derived from the deposit and investment of money in the fund.

Connect for Health Colorado Board Duties

The bill adds to the duties of the Board of Connect for Health Colorado. The Board shall conduct a survey, through Connect for Health Colorado, of consumers who purchased the standardized health plan, addressing the consumers’ purchasing experience and whether the plan addresses health equity and disparity issues.

Professional Disciplinary Action

The following professionals can face disciplinary action by their licensing board if they do not accept patients enrolled in the Colorado Option or balance bill enrolled patients:

- Acupuncturist
- Chiropractors
- Direct-entry Midwives
- Massage Therapists
- Physicians
- Physician Assistants
- Mental Health Professionals
- Nurses
- Nurse Aides
- Occupational Therapists
- Optometrists
- Physical Therapists
- Podiatrists

Health Facilities & the Colorado Option

A health facility licensed or certified by CDPHE that provides services covered under the Colorado Option must accept Colorado Option enrolled consumers, cannot balance bill enrolled patients, and accept the fee schedule established for the Colorado Option. CDPHE may suspend, revoke, or impose conditions on a health facility’s license or certificate of authority for noncompliance.

Effective Date

The bill is effective upon the Governor’s signature or if the Governor allows it to become law without their signature.

Fiscal Note

The fiscal note estimates that state expenditures include costs to establish and implement the standardized plan to be offered by private health insurance carriers, as well as to seek federal approval of a State Innovation Waiver. These costs are estimated to be \$868,684 and 3.5 FTE in FY 2021-22, and \$790,424 and 4.9 FTE in FY 2022-23.

Reasons to Support

Many Colorado residents continue to struggle with health insurance costs and too few options. A public option program could offer consumers across the state a lower-cost plan option than would otherwise not be available. This two phased approach gives the industry - including hospitals, insurance carriers, and drug manufacturers - the chance to work together to lower the driving costs of health care first. If the industry is not able or willing to realize lower health care costs while maintaining quality and access, the state will move forward with the Colorado Health Insurance Option. This is a long term solution to create affordable insurance options, holding the entire health care industry accountable for cost, in order to make it easier for Coloradans, including people of all races and incomes, to afford and access health insurance – assuring everyone an equitable chance for good health.

The standardized plan means there will be a uniform set of services and out-of-pocket costs that the health care industry must comply with. This will make it easier for consumers to access care with their coverage without fear of unpredictable costs or high deductibles. It will also make it easier for consumers to compare plans from different carriers because they will all have to meet the same standards for out-of-pocket costs and plan benefits.

Small businesses have consistently seen premium hikes, making it increasingly difficult for business owners to afford and provide coverage to their employees. Small businesses will have access to the more affordable plans in phase one and phase two. This will ensure that small businesses have more affordable options and can more easily offer health benefits and retain employees.

Supporters

- Centennial State Prosperity
- Colorado Center on Law & Policy
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Good Business Colorado
- Healthier Colorado
- Justice Reskill
- League of Women Voters
- Mental Health Colorado

Reasons to Oppose

If too many people move to the public option, some believe it could negatively impact the private marketplace and possibly increase prices for those who buy health insurance without the use of tax credits. Some assert that increased government intervention in the marketplace could destabilize both the private and public insurance markets. The small group market has a different regulatory framework than the individual market, which could make standardizing the plan product difficult and skew the affordability benchmarking.

During Phase One, some assert that physicians and other health care providers will be the levers used by other health care industries to achieve the premium cost-cutting goals.

The state option is likely based on a fee for service model, which moves the system away from value-based reimbursement, a system that many believe offers the best chance of incentivizing the most effective care and cutting cost.

In Phase Two, the mandate for providers to participate may harm access to care, or “crowd out” Coloradans on other insurance plans. If rural health care facilities, who already see disproportionately higher rates of public insurance, are required to accept the Colorado Option, they may have to reduce care for people who

are covered by public insurance (since public insurance also has limited fee schedules, often not covering the full cost of care) in order to remain financially solvent.

Opponents

- Adams County Regional Economic Partnership
- America's Health Insurance Plans
- Americans for Prosperity
- Anthem Blue Cross and Blue Shield
- Centennial Institute at Colorado Christian University
- Cigna
- Colorado Ambulatory Surgery Center Association
- Colorado Association of Health Plans
- Colorado Association of Medical Equipment Services
- Colorado Bankers Association
- Colorado Chamber of Commerce
- Colorado Chapter, College of Emergency Physicians
- Colorado Competitive Council
- Colorado Concern
- Colorado Farm Bureau
- Colorado Obstetrical & Gynecological Society
- Colorado Radiological Society
- Colorado Rural Health Center
- Colorado Society of Anesthesiologists
- Colorado Springs Chamber
- Colorado State Association of Health Underwriters
- Columbine Health Plan
- CVS Health
- Denver Metro Chamber of Commerce
- Douglas County
- Douglas County Business Alliance
- HCA- The Healthcare Company
- Kaiser Foundation Health Plan
- Kaiser Permanente
- Mednax
- Optum
- Pacific Dental Services
- Rocky Mountain Mechanical Contractors Associations
- South Metro Denver Chamber
- United Health Care
- U.S. Anesthesia Partners of Colorado

Other Considerations

Organizations with an Amend Position

- Children's Hospital Colorado
- Colorado Academy of Family Physicians
- Colorado AFL-CIO
- Colorado Hospital Association
- Denver Health & Hospital Authority
- Peak Health Alliance
- SCL Health
- Service Employees International Union
- UCHealth

Is there room to negotiate the amount of premium rate reduction targets to a lower number?

Reductions in costs in the health care industry could have a ripple effect to the wider economy as a significant portion of cost in the health care industry is for personnel. Is there are way to study that impact?

Is there a course of action in the case that either phase of the bill creates insurmountable unintended consequences?

In the introduced version of the bill, why is it not grounds for disciplinary action to not accept patients enrolled in the Colorado Option or balance bill enrolled patients for the following licensed/registered/certified professions?

- Audiologists
- Hearing Aid Providers
- Pharmacists
- Psychiatric Technicians

- Respiratory Therapists
- Speech-language Pathologists
- Surgical Assistants and Surgical Technologists

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 analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.



POLICY

April 13, 2021





TOPICS OF DISCUSSION

01

POLICY & PROCESSES

02

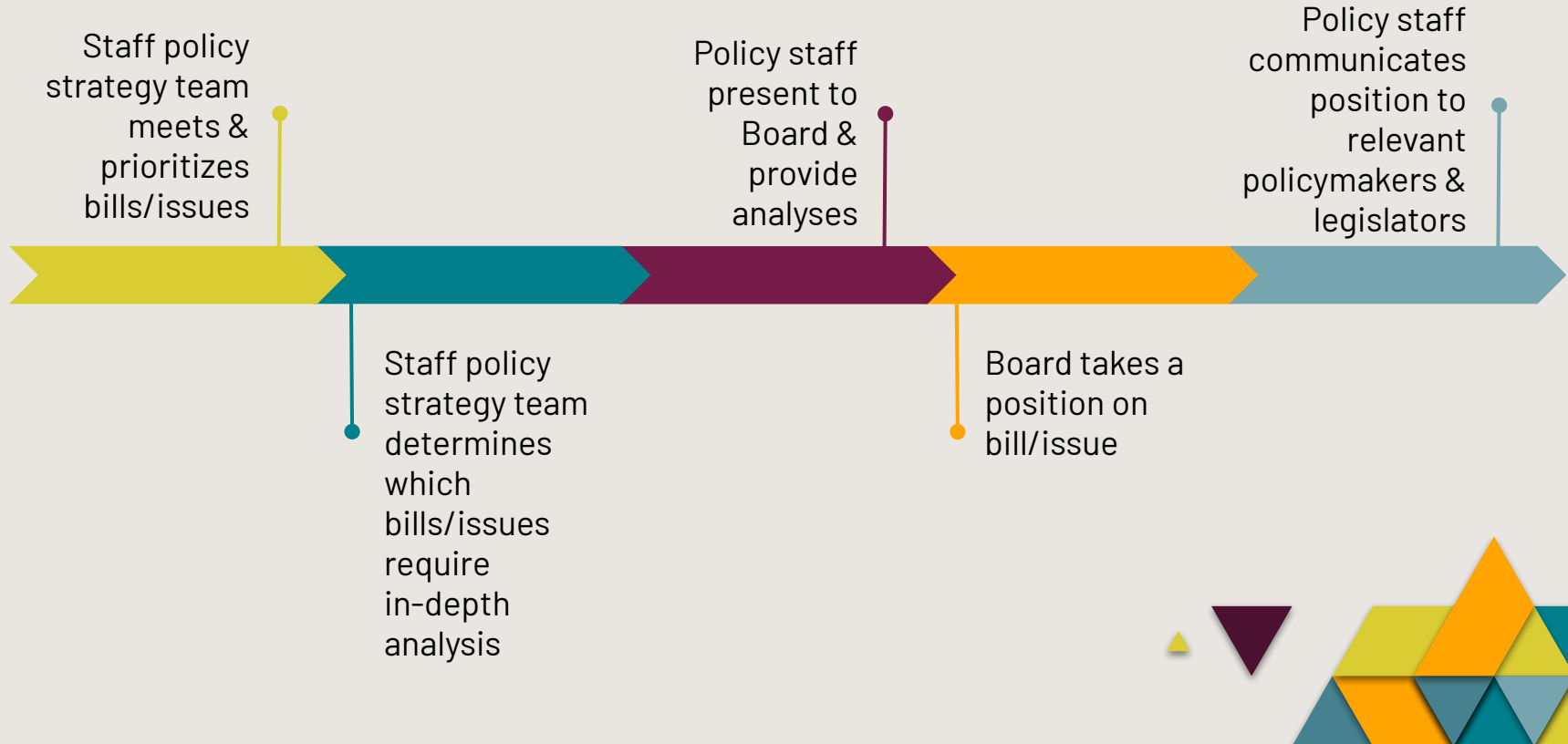
STATE





HOW THE BOARD TAKES POSITIONS

THE PROCESS



PRIORITIZATION

PRIORITY 1	Potentially significant impact on the health of the community or Health District operations
PRIORITY 2	Potential impact, but less significant
PRIORITY 3	Other



BOARD POSITIONS

Positions Taken by Motion

- Strongly Support
- Support
- Oppose
- Strongly Oppose
- No Position (Neutral)

The Board May:

- Take a position on portions or particular concepts
- Decline to take a position



EXAMPLES

The Board voted to Support SB21-016, but encourage only incorporation of screenings and services that are recommended by U.S. Preventive Services Task Force, Health Resources and Services Administration, and the National Academy of Medicine.

The Board appreciates the intent of the bill but does not recommend that it be passed without Amendments

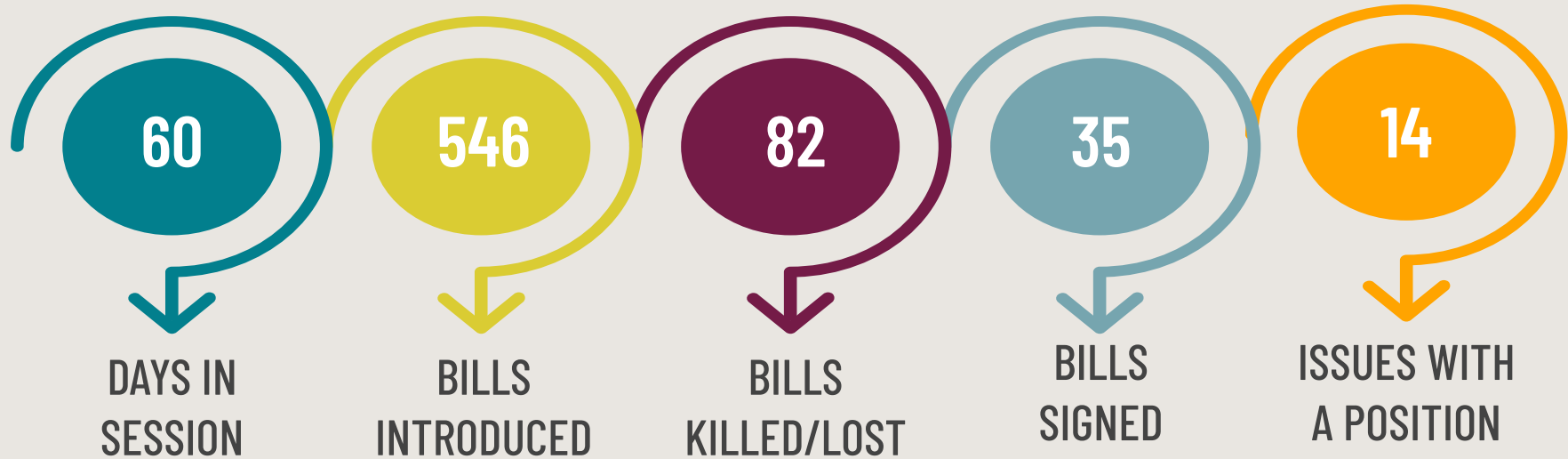
The Board of Directors voted to support the funding of LARC in 2018-2019 budgetary process.

The Board of Directors voted to support components of this bill. The board strongly supports syringe access programs in hospitals and allowing schools to develop policies regarding naloxone. The board supports the study of penalties by the Commission. The board did not take a position on the pilot-program supervised injection facility.



STATE





THE STATE BUDGET- THE BIG PICTURE

**\$34.1
Billion**

Total Spending

11% increase from
the current fiscal
year

**\$13.1
Billion**

General Fund

Other ⅔ from
federal funds and
fees collected by
the state

**\$1.7
Billion**

Reserve Fund

13.5% of General
Fund- largest
amount in a
couple decades

**\$800
Million**

Colorado Stimulus

Earmark for
specific bills to help
recover from
COVID & economic
distress

**\$21
Million**

**Public Health
Infrastructure**

Staffing CDPHE,
funding to local
public health
agencies



COLORADO STIMULUS



Small Business
Grants & Sales Tax
Relief



Infrastructure
Shovel-ready, clean
energy, main street
revitalization, state
park access



Workforce
Educator licensure,
SNAP employment
& training, training
for re-entry from
incarceration,
funding for
workforce boards



Rural
Wildlife, water
plan, rural
economic
development,
drought response,
local agriculture



Families
School tutoring,
mental health
screenings in school,
funding for mental
health hotline, child
care business support,
funding for hotel
rooms for unhoused
folks, affordable
housing incentive,
school construction
grants



SB21-199: REMOVE BARRIERS TO CERTAIN PUBLIC OPPORTUNITIES

SENATE: Jaquez Lewis (D) & Winter (D)
HOUSE: Esgar (D) & Gonzales-Gutierrez (D)

HEARING TODAY
Senate State, Veterans & Military Affairs

CURRENTLY:

- Federal and state law require verification of lawful residency for public benefits
- State agency or political subdivision cannot enter into or renewing a public contract with a contractor who knowingly employs or contracts persons who are undocumented
- State agencies and local governments must use secure and verifiable identity documents when providing services or issuing official documents

THIS BILL:

- Removes the requirement to verify lawful presence for state or local public benefits
- Removes public contracting requirement from statute
- Removes statute regarding use of secure & verifiable identity documents



HB21-1150: CREATE THE COLORADO OFFICE OF NEW AMERICANS

HOUSE: Jodeh (D)

SENATE: *None*

April 15 Hearing
House Finance

The bill creates the Colorado Office of New Americans (ONA).

The ONA serves as the point of contact for immigrant-serving state agencies, private sector organizations, and the public about immigrant issues in Colorado.

As its main priority, the ONA is required to implement a statewide strategy to facilitate economic stability and promote successful economic, social, linguistic, and cultural integration by investing in the success of immigrants in Colorado.



HB21-1232: STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION

HOUSE: Roberts (D) & Jodeh (D)
SENATE: Donovan (D)

TBD Hearing for Action Only
House Health & Insurance

Two-phased approach??

Standardized plan only??



SB21-085: ACTUARIAL REVIEW HEALTH INSURANCE MANDATE LEGISLATION

SENATE: Ginal (D) & Smallwood (R)

HOUSE: Lontine (D)

TBD Hearing

Senate Appropriations

The bill requires the DOI to retain a contractor for the purpose of performing actuarial reviews of proposed legislation that may impose a new health benefit mandate or cut or reduce a benefit for health benefit plans. The contractor, under the direction of the division, shall conduct an actuarial review of up to 5 legislative proposals for each regular legislative session, each at the request of a member of the general assembly and by approval of the Senate President and House Speaker.



The Board appreciates the intent of the bill but does not recommend that it be passed without Amendments, because it is an extraordinarily complex challenge to undertake quality analyses, this is likely to have major impacts into the future, and many amendments should be considered. The Board's recommendation is that this concept be referred to a Task Force for further development before passage. At first look, the following amendments should be considered, and there may well be others:

1. **Public programs should be excluded from actuarial review.**
2. **The bill should allow for the request actuarial reviews if an insurance benefit is being cut/reduced- not just adding new benefits**
3. Greater focus on health equity (i.e. **contractor selected through a process that includes stakeholders; the report should include an equity analysis; adding a section of language that includes identifying who would benefit from the proposal**)
4. ~~The description of potential savings should be broken into multiple levels in the same way that the costs are, and look for savings over a window of time.~~
5. **The length of time required for the actuarial analysis should not prohibit a bill from moving in a single legislative session, which may require such bills to be flagged before a regular session begins.**
6. **Any mandate that results in a premium impact of less than 1% should be deemed negligible and the contractor should not perform the estimates in sections in IV-VII for that mandate. If an equity review or language that outlines the demographics of who would benefit from proposed legislation is added to the bill, the Board urges that that information still be gathered if a premium impact is deemed negligible.**



HB21-1198: HEALTH CARE BILLING REQUIREMENTS FOR INDIGENT PATIENTS

HOUSE: Jodeh (D)

4/21 Hearing

SENATE: Buckner (D) & Kolker (D) House Health & Insurance

The bill requires hospitals to screen uninsured patients for health coverage options and potential financial assistance for which they may be eligible. Each hospital must use a uniform application developed by the Department of Health Care Policy and Financing (HCPF) when screening a patient.

It also limits the amount that low-income patients pay for certain health services by tying what they owe to an established rate while also limiting the size of payments charged on a monthly basis.

In addition, it prohibits hospitals from sending a patient to collections unless they have screened the patient for coverage and assistance, offered a payment plan, and provided information regarding patient rights.



HB21-1198: Staff Recommended Position

The bill should be amended so that it:

- Applies only to hospitals and freestanding emergency departments
- **Adds language for what rate to use when Medicare does not have a rate to use for reference (for example, pregnancy)**
- Incorporates provider protections in the case of patients deliberately misreporting their income
- Removes the provision regarding the cancellation of debt after 36 months
- **Removes the requirement of providing a payment plan that does not exceed 5% of monthly income for patients that are non-qualifying**





CREDITS

- ◀ Presentation template by [Slidesgo](#)
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SB21-085: ACTUARIAL REVIEW HEALTH INSURANCE MANDATE LEGISLATION

Concerning actuarial reviews of proposed legislation that may impose a new health benefit mandate on health benefit plans.

Details

Bill Sponsors:	Senate – Ginal (D) and Smallwood (R) House – Lontine (D)
Committee:	Senate Finance Committee <u>Senate Appropriations Committee</u>
Bill History:	2/16/2021- Introduced in Senate 3/30/2021- Senate Committee on Finance Refer Amended to Appropriations
Next Action:	Hearing in Senate <u>Finance Appropriations</u> Committee
Fiscal Note:	March 22, 2021

Background

The purpose of this policy brief is to provide an overview of the amended bill to the Board of Directors before discussion at the April 13, 2021 Board meeting. The track changes represent the changes that have occurred in this brief since it was presented during the March 9, 2021 Board meeting.

Bill Summary

Actuarial Review

By November 1, 2021, the Division of Insurance (DOI) is to retain an an contractor-actuary that has experience with health care policy, equity, and actuarial reviews. The contractor is to perform actuarial reviews on proposed legislation that may impose a new health benefit mandate on health plans or reduce or eliminate mandated coverage under health benefit plans. Under the direction of the DOI, the contractor is to conduct such reviews of up to 5 legislative proposals that are being or will be considered for each regular session, at the request of a legislator, who is proposing the legislation. The contractor shall not conduct an actuarial review of a proposal unless the request is approved by the Senate President and Speaker of the House. If the DOI gets more than 5 requests, the chair of the House Health & Insurance Committee and the chair of the Senate Health & Human Services Committee shall select which legislative proposals the contractor is to review. A legislator who requests an actuarial review of the proposed legislation shall submit the request to the DOI before September 1 of the year preceding the regular legislative session for which the legislation is proposed.

An actuarial review must consider the predicted effects of the proposal during the 5 years immediately following the effective date of the proposed legislation, including:

- An estimate of the number of Coloradans who will be directly affected by the proposal
- Estimates of changes in the rates of utilization of specific health care services that may result from the proposal
- Estimates for any changes in consumer cost sharing that would result from the proposal, including information concerning who would benefit from the changes, which information, if available, must be disaggregated, at a minimum by race, ethnicity, sex, gender, and age
- Estimates of any premium increases for plans on the individual, small-group, and large-group markets (in terms of percentage increase as well as per-member, per-month charges)

- An estimate of the increases or decreases, if any, in the cost of coverage for the state employee group benefit plans, regardless of whether the proposal amends that section of statute or applies to the plans (in terms of dollar amounts)
- ~~An estimate of the increase in expenditures for Medicaid, if any, regardless whether the proposal amends that section of statute (in terms of dollar amounts)~~
- ~~An estimate of the increase in cost of coverage, if any, that would result from the proposal for employers with fewer than 100 employees, between 100 and 500 employees, and employers with 500 or more employees (in terms of dollar amounts)~~
- An estimate of the potential long-term cost savings associated with any new benefit or service described in the proposal (in terms of dollar amounts)
- Identification of any potential health benefits that would result from the proposal, including information concerning who would benefit from the changes, which information, if available, must be disaggregated, at a minimum by race, ethnicity, sex, gender, and age
- Information, if available, concerning any disproportionate effects that the proposed legislation may have on consumers as a result of their race, ethnicity, sex, gender, or age
- An estimate of the out-of-pocket health care savings associated with any new health benefit service described in the proposed legislation, including information concerning who would benefit from the changes, which information, if available, must be disaggregated, at a minimum by race, ethnicity, sex, gender, and age

In performing these reviews, the contractor shall utilize data from the all-payer claims database. Carriers are encouraged to provide information to and cooperate with the contractor and the DOI. A request for an actuarial review by a legislator and any information submitted to the contractor for the purpose of the review is work product¹ under the Colorado Open Records Act. Therefore, that request and submitted information would not be considered a public record and would not be open for public request and review. For the use of this section “health benefit plan” excludes Medicaid and the Children’s Health Plan Plus (CHP+). The Commissioner of Insurance may promulgate rules necessary to implement this section regarding the actuarial reviews. The actuarial review option is repealed in statute on November 1, 2024.

Actuarial Reviews in Fiscal Notes

In preparing a fiscal note, Legislative Council Staff (LCS) is to include the information produced by the contractor (to the extent practicable) as well as an indication of how the contractor’s entire report can be obtained. If no information is produced by the contractor for the proposal, that fact must be indicated in the fiscal note. This section requiring that LCS is to note that an actuarial review has been performed in fiscal notes is repealed November 1, 2024.

Repeal

The bill repeals current statutory language that requires entities seeking legislative action that would mandate coverage to submit a report to the committee of reference that addresses the social and financial impacts of such coverage, including the efficacy of the treatment of service proposed.

Definitions in Statute

In Article 16, Title 10, related to health care insurance, the bill adds that only in respect to the section regarding actuarial reviews does the term “health benefit plan” exclude Medicaid and CHP+.

Effective Date

The bill, subject to a petition, takes effect at 12:01am on the day following the expiration of the 90 day period after the final adjournment of the General Assembly.

¹ C.R.S. § 24-72-202(6.5)

Fiscal Note

For FY2021-22, the introduced version of the bill requires an appropriation of \$104,783 to the Department of Regulator Agencies. The following chart from the fiscal note delineates where these funds would be used. Please note that \$13,925 of the below funds would be centrally appropriated costs.

Table 2
Expenditures Under SB 21-085

	FY 2021-22	FY 2022-23
Department of Regulatory Agencies		
Personal Services	\$21,783	\$21,783
Actuarial Contractor	\$50,000	\$50,000
All-Payer Claims Database Fees	\$33,000	\$33,000
Centrally Appropriated Costs ¹	\$13,925	\$13,925
Total Cost	up to \$118,708	up to \$118,708
Total FTE	0.2 FTE	0.2 FTE

¹ Centrally appropriated costs are not included in the bill's appropriation.

Reasons to Support

Independent data could inform decisions regarding the introduction and passage of health plan benefit legislation. The analyses could help legislators see the possible costs and benefits of mandating certain services be included in the benefits package of health insurance plans regulated by the state.

Supporters

- America's Health Insurance Plans
- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Association of Health Plans
- Colorado Chamber of Commerce
- Colorado Competitive Council
- Colorado Hospital Association
- Colorado State Association of Health Underwriters
- Craig Hospital
- CVS Health
- Denver Health
- Denver Metro Chamber of Commerce
- HCA- The Healthcare Company
- Healthier Colorado
- Kaiser Foundation Health Plan
- Kaiser Permanente

Reasons to Oppose

There remains concern about the timing of such analysis, it is likely that it could affect consumer engagement as many proposals generated by consumers may not occur until after the September 1st deadline. This timeline is before new legislators are elected in election years and typically well before drafts of legislation have been started. This bill could restrict health care innovation as it may tie all stakeholders' hands with a difficult timeline.

Although reviews are not mandated, it may become a de facto requirement for a bill to move forward in the legislative process.

Opponents

- Opposition has not been made public at this time Colorado Center on Law & Policy
- Colorado Consumer Health Initiative

Other Considerations

As the bill was amended in the Senate Finance committee, the bill includes more considerations regarding the equity of the changes being proposed. Further, the bill no longer includes any benefit changes to public insurance programs, like Medicaid and CHP+. The required submission by September 1, the year prior to the regular legislative session, gives more likelihood that such legislation with health benefit changes could be passed in a single legislative session. Finally, the amended bill also allows for reviews to be requested for not only benefit additions but also benefit reductions.

- Would there be enough funding to truly investigate and review the potential effects of proposed legislation?
- Would the DOI be able to find a contractor that can complete the actuarial review and also have the expertise to review the demographic impacts?

About this Brief

This brief 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 brief is accurate to staff knowledge as of date printed. For more information about this brief or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org

4/9/2021

STAFF: ALYSON WILLIAMS &
IDA COSSITT-GLESNER

POLICY ANALYSIS

HB21-1198: HEALTH-CARE BILLING REQUIREMENTS FOR INDIGENT PATIENTS

Concerning health-care billing requirements for indigent patients receiving services not reimbursed through the Colorado Indigent Care Program, and, in connection therewith, establishing procedures before initiating collections proceedings against a patient.

Details

Bill Sponsors: House – Jodeh (D)
Senate – Buckner (D) and Kolker (D)
Committee: House Health & Insurance
Bill History: 3/4/2021- Introduced in House
Next Action: 4/21/2021- Hearing in House Health & Insurance Committee
Fiscal Note: 3/30/2021

Bill Summary

The bill requires hospitals to screen uninsured patients for health coverage options and potential financial assistance for which they may be eligible. Each hospital must use a uniform application developed by the Department of Health Care Policy and Financing (HCPF) when screening a patient. It also limits the amount that low-income patients pay for certain health services by tying what they owe to an established rate while also limiting the size of payments charged on a monthly basis. In addition, it prohibits hospitals from sending a patient to collections unless they have screened the patient for coverage and assistance, offered a fair payment plan, and provided information regarding patient rights.

Issue Summary

Insurance Coverage

Medical insurance is a contractual relationship between an individual or family and a health care cost administrative company. Medical insurance can either be public, when administered by government entities, or private, as when administered through an employer's relationship with an insurance company.¹ In exchange for monthly payments, or a premium, insurance companies help individuals and/or families finance medical care and access affordable 'in-network' medical providers who have also formed a contractual relationship with the same insurance company.¹ Medical insurance often covers certain medical tests, office visits, treatments, supplies, medications and services.² Most, but not all, medical insurance plans require members to pay a copay (e.g. a flat fee for care at the time of service), as well as co-insurance (e.g. a certain percentage of the total cost of medical service covered by the insurance). Such co-insurance is not usually activated until members pay a certain quantity of their own money (e.g. their deductible). Members are expected to pay up to, and no more than, their out-of-pocket maximum - a pre-determined amount for covered services by in-network providers. The insurance company's formulary, or list of drugs it covers, determines the level of member cost sharing requirements for different prescription drugs.²

¹ HealthCare.gov. "Health insurance: How it protects you from health and financial risks", 2021. <https://www.healthcare.gov/why-coverage-is-important/coverage-protects-you/>

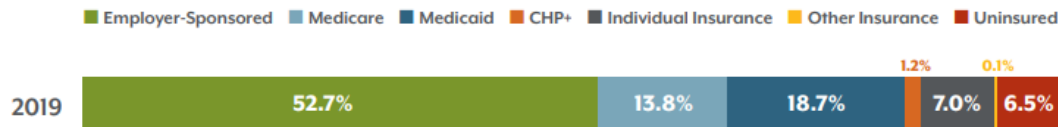
² BlueCrossBlueShield Minnesota "How health insurance works", 2021. <https://www.bluecrossmn.com/shop-plans/individual-and-family-plans/how-health-insurance-works>

Attempts to Cover More Americans; Remaining Need

However, many Americans have been unable to obtain medical insurance, due to cost and/or inability to obtain insurance through employment. The Affordable Care Act (ACA) sought to address this lack of medical insurance coverage by extending Medicaid coverage to those living in households below 133% of federal poverty level (FPL), and by providing subsidies for Marketplace coverage for individuals living in households with incomes below 400% of FPL. More recently, the American Rescue Plan Act, passed in March 2021, has temporarily expanded subsidies for those with incomes above 400% of FPL.³ Following the ACA, the number of uninsured nonelderly Americans declined by 20 million, dropping to an historic low in 2016. However, beginning in 2017, the number of uninsured nonelderly Americans increased for three straight years, growing by 2.2 million from 26.7 million in 2016 to 28.9 million in 2019, and the uninsured rate increased from 10.0% in 2016 to 10.9% in 2019.⁴ Recently, according to data from the U.S. Bureau of Labor Statistics and The Urban Institute, the U.S. uninsured rate rose 21 percent between 2018 and 2020. Each state also saw an increase in their uninsured rates during this period. The COVID-19 pandemic also contributed to an expansion of uninsured rates, as 5.4 million Americans lost health insurance coverage due to job loss between just February and May of 2020.⁵

Insurance Coverage in Colorado

According to the 2019 Colorado Health Access Survey (CHAS) administered by the Colorado Health Institute, 93.5% of Coloradans were insured in 2019.⁶ The majority of Coloradans (52.7%) are covered through plans provided by employers. Another 33.7% are covered by public programs, including Medicare, Medicaid, and the Child Health Plan Plus (CHP+). And 7% purchase their insurance on the individual market, either through the marketplace run by Connect for Health Colorado (which offers subsidies for those with eligible incomes), or insurance that is offered off the marketplace. The figure below, from the Colorado Health Institute (CHI), demonstrates the proportion of residents in the different types of insurance coverage offered in Colorado.⁶



However, in 2019, 6.5% of respondents in the CHAS survey reported being uninsured. Cost has typically been the biggest barrier to coverage in Colorado. In recent years, more people in Colorado are feeling this financial barrier to medical insurance and care. For those who reported being uninsured, 89.6% cited that the cost of the insurance was a barrier to purchasing coverage, which is much greater than the 78.4% that had the same response in 2017.¹

The uninsured rate, though, varies significantly throughout the state – ranging from 2.6% in Jefferson County to 14.3% in the I-70 mountain corridor. Additionally, in 2019, despite such a low uninsured rate, 17.3% (or one in six) of Coloradans have switched, lost or gained coverage in the previous year. Such a change in

³ Kaiser Family Foundation (KFF). “How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured”, March 25, 2021. <https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/>

⁴ Kaiser Family Foundation (KFF). “Key Facts About the Uninsured Population”, November 6, 2020. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=The%20uninsured%20rate%20in%202019%20ticked%20up%20to%2010.9%25%20from,significantly%20below%20pre%20DACA%20levels>

⁵ Becker’s Hospital Review. “States Ranked by Uninsured Rates”, July 15, 2020. <https://www.beckershospitalreview.com/rankings-and-ratings/states-ranked-by-uninsured-rates.html>

⁶ Colorado Health Institute (CHI) “Progress in Peril: 2019 Colorado Health Access Survey Storybook” (Jan. 2020). https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf

insurance status can cause disruption in care or strain finances. 53% of the Coloradans who switched insurers or lost coverage said it was due to loss of employer-sponsored coverage.⁷

Each of the 64 counties in Colorado has at least one carrier providing insurance on the Connect for Health Colorado marketplace. For the 2021 plan year, 10 of Colorado's 64 counties had only one carrier offering plans, a decrease from 22 counties for the 2020 plan year.⁸

The expansion of public health insurance programs impacted the lowest-income Coloradans the most, providing coverage for all those eligible for Medicaid. However, Coloradans with incomes at 201-300% FPL, who are typically not eligible for Medicaid, struggle with affordability, and saw their uninsured rate nearly double in recent years (6.6% in 2015 to 11.8% in 2019).⁹ Additionally, just over 10% of Hispanic/Latinx Coloradans are uninsured, a significantly higher percentage than the overall 6.5% uninsured rate for all of Colorado. While this is a marked decrease since 2009 (when it was nearly 27.6%), Hispanic/Latinx Coloradans experience significantly higher uninsured rates than any other racial or ethnic group in the state. Further, Black (non-Hispanic / Latinx) Coloradans are nearly twice as likely to have had problems paying a medical bill than white (non-Hispanic / Latinx) Coloradans (30.2% versus 16.5%).¹⁰

After falling from 12% to 4% between 2013 and 2016, Larimer County survey respondents aged 18-64 who reported having no health insurance jumped to 8% in 2019. In 2019, 53.8% of Larimer County adults reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.¹¹

Medical Debt

In 2019, just over 20% of Coloradans cited cost as the reason they did not seek treatment by a doctor or specialist or obtain prescription services. Between 2017 and 2019, the percentage of Coloradans who struggled to pay medical bills rose from 14.0% to 18.1%. Of those who had difficulty paying medical bills in 2019, 70.5% saved less or took funds out of savings, 53.9% took on credit card debt, 32.6% were unable to pay for necessities like rent, food or heat, 28.4% worked extra hours or started another job, 18.6% took out a loan, and 3.7% declared bankruptcy.¹²

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986¹³ to ensure that patients have access to emergency services regardless of their ability to pay.¹⁴ EMTALA imposes specific responsibilities on all Medicare participating hospitals, which apply to all patients. The three central provisions include:

1. The hospital must provide an appropriate medical screening exam to anyone coming to the emergency department (ED) seeking medical care;

⁷ CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

⁸ Division of Insurance "Same eight companies returning to offer individual health insurance plans 2021 while number of plans increases" (July 9, 2020). <https://doi.colorado.gov/press-release/same-eight-companies-returning-to-offer-individual-health-insurance-plans-for-2021>

⁹ CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

¹⁰ CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

¹¹ Health District of Northern Larimer County "2019 Community Health Assessment" (2020) <https://www.healthdistrict.org/2019-community-health-assessment>

¹² CHI "2019 Colorado Health Access Survey: Health Insurance Coverage", October 9, 2020.

<https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-insurance-coverage>

¹³ 42 U.S.C. §1395dd

¹⁴ CMS. "Emergency Medical Treatment and Labor Act" <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>

2. For anyone that comes to the hospital and the hospital determines that the individual has an emergency medical condition, the hospital must treat and stabilize the emergency medical condition, or the hospital must transfer the individual; and
3. A hospital must not transfer an individual with an emergency medical condition that has not been stabilized unless several conditions are met that includes effecting an appropriate transfer.

Colorado Indigent Care Program (CICP)

The Colorado Indigent Care Program (CICP) is a program administered by the Colorado Department of Health Care Policy and Financing (HCPF). Although CICP is not health insurance, the program strives to partially compensate participating providers who care for the uninsured and underinsured who have incomes at or below 250% of FPL¹⁵. Through provider compensation, CICP delivers discounted health care services to low-income people and families at participating clinics and hospitals throughout the state. Since CICP is not health insurance, medical services discounted under CICP may be different at each participating hospital or clinic. The CICP discount only applies to qualifying services after any health insurance has been applied to the cost. The qualifying individual or family then pays either the balance remaining after insurance or the CICP co-payment, whichever is lower. Potential CICP enrollees must apply to the program with personal identification, household income and resource information for themselves and their family. To be eligible, they must be legal Colorado residents, meet income and resource guidelines, cannot be eligible for Medicaid or the Child Health Plan Plus (CHP+), and may be covered by Medicare or other health insurance.¹⁶

General Income Limits for CICP Eligibility¹⁷

<i>Family</i>	Approximate Annual Income	
	up to \$31,900	up to \$2,658
	up to \$43,100	
	up to \$54,300	up to \$4,525
	up to \$65,500	

This Legislation

Definitions

Health-care facility. A licensed general hospital, University of Colorado hospital authority, Denver Health and Hospital Authority, any freestanding emergency department (FSED), any outpatient facility that is affiliated with or operating under these hospitals or FSEDs.

Health-care services. Any services included in furnishing of medical, behavioral, mental health, or substance use disorder care; dental, or optometric care; hospitalization; or nursing home care to an individual, as well as any other services for the purpose of preventing, alleviating, curing, or healing human physical illness or injury, or behavioral, mental health, or substance use disorder. This includes the rendering of the services through the use of telehealth.^{18,19}

Licensed health-care professional. Any health care professional who is registered, certified, or licensed or a person who provides services under the supervision of a professional, and who provides health care services in a health care facility.

¹⁵ Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program (CICP) Health Care Reform Frequently Asked Questions (FAQ) for Providers", September 20, 2013. <https://cchn.org/wp-content/uploads/2013/10/CICP-Provider-FAQ.pdf>

¹⁶Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program", 2019. <https://www.colorado.gov/pacific/hcpf/colorado-indigent-care-program>

¹⁷Colorado Department of Health Care Policy & Financing. "Colorado Indigent Care Program", 2019. <https://www.colorado.gov/pacific/hcpf/colorado-indigent-care-program>

¹⁸ Definition from C.R.S. §10-16-102(33)

¹⁹ Telehealth defined at: C.R.S. §10-16-123 (4)(e)

Non-CICP health-care services. Health care services provided in a health care facility for which reimbursement under the Colorado Indigent Care Program (CICP) is not available.

Qualified patient. An individual whose household income is no more than 250% of the federal poverty level (FPL) and who received a health care service at a health care facility.

Screen/Screening. A process identified by HCPF rule where health care facilities assess the patient related to eligibility criteria and determine whether the patient is likely to qualify for public health coverage or discounted care, inform the patient of the determination, and provide information to the patient about how the patient can enroll in public coverage.

Requirement to Screen Patients for Public Programs & Discounted Care

Starting June 1, 2022, a health care facility must screen each uninsured patient, unless they decline, for:

- Public health insurance programs, including Medicare, Medicaid, Emergency Medicaid, Children's Health Plan Plus
- Discounted care through CICP, if the service received is eligible for reimbursement through the program
- Discounts on services not eligible for CICP reimbursement, as outlined in the next section

Health facilities must use a single, uniform application developed by HCPF to conduct screening. If a facility determines that the patient is ineligible for discounted care, it must provide the patient with notice of that determination and an opportunity for the patient to appeal, in accordance with HCPF rules. If the patient declines the screening, the facility must document the patient's decision, in accordance with HCPF rules. If screening is requested by an insured patient, the facility must do so to see if they qualify for discounted care.

Discounted Care for Services Not Eligible for CICP

If a screened patient is determined to be a qualified patient, a health care facility and a licensed health care professional must, for emergency and other non-CICP services:

- Limit the charged amounts to no more than 80% of Medicare rates
- Collect charged amounts (not including those owed by third-party payers) in monthly installments that are no more than 5% of the patient's monthly household income
- After a total of 36 months of payments, consider the patient's bill to be paid in full and permanently end any and all collections activities on any unpaid balance

A facility cannot deny discounted care on the basis that the patient has not applied for any public benefits program or adopt or maintain policies that result in the denial of admission or treatment of patient because they are uninsured, may qualify for discounted care, require extended or long-term treatment, or has an unpaid medical bill.

Notification of Patient's Rights

A health facility shall make information about patient's rights and the uniform application, both developed by HCPF, available to the public and each patient. At a minimum, the facility shall post that information in all required languages conspicuously on its website, including a link on the main landing page, make the information available in patient waiting areas, make it available to each patient or legal guardian (verbally or in writing) in their primary language before the patient is discharged, and inform each patient on the billing statement of their rights and provide the website, e-mail address, and phone number where information may be obtained in the patient's primary language.

Facility Reporting Requirements

Starting June 1, 2023, and each June 1 thereafter, each health care facility shall collect and report to HCPF data that HCPF deems necessary to evaluate compliance across race, ethnicity, and primary-language-spoken patient groups. If a facility is not capable of disaggregating the required data, then it should report to HCPF the steps the facility is taking to improve data collection and the date by which the facility will be able to disaggregate the reported data.

By April 1, 2022, the Medical Services Board shall promulgate rules necessary for administration and implementation, at a minimum the rules must:

- Outline a process for an insured patient to request a screening
- Outline a process for documenting that a patient has declined a screening
- Establish the process and maximum number of days that a facility has to initiate screening, request information needed for the screening, and to complete the screening
- Outline the requirements for notifying the patient of the results of the screening, including an explanation of the basis for a denial and the process for appeal
- Establish guidelines for patient appeals regarding eligibility for discounted care for services not CICIP eligible
- Establish a methodology that all facilities must use to determine monthly household income, it cannot consider a patient's assets
- Identify the documents that may be required to establish income eligibility for discounted care using the minimum amount of information needed
- Identify the steps a facility and health professional must take before sending patient debt to collections
- Create a single uniform application that a facility shall use when screening

When promulgating rules, HCPF shall align the processes of qualifying for and appealing denials of eligibility for CICIP and discounted care that is not CICIP eligible. Additionally, HCPF shall consider potential limitations relating to EMTALA.

By April 1, 2022, HCPF shall develop a written explanation of patient right's that is written in plain language at a 6th grade reading level and translated into all languages spoken by 10% or more of the population in each county of the state. Each facility shall make the explanation available to the public and each patient, as previously outlined. Additionally, HCPF is to establish a process for patients to submit a noncompliance complaint to HCPF by phone, mail, or online. HCPF must conduct a review within 30 days after receiving a complaint. HCPF shall periodically review facilities and professionals to ensure compliance. If HCPF finds noncompliance, HCPF shall notify the facility or professional and they have 90 days to file a corrective action plan with HCPF that must include measures to inform the patient about noncompliance and provide a financial correction. A facility or licensed professional may request up to 120 days to submit a corrective action plan. HCPF may require the facility or professional in noncompliance to develop and operate under a corrective action plan until HCPF determines they are in compliance. If the noncompliance is determined to be knowing or willful or there is a repeated pattern of noncompliance, HCPF may fine the facility or professional no more than \$5,000. If the facility or professional fails to take corrective action or fails to file a corrective action plan, HCPF may fine them no more than \$5,000 a week until they take corrective action. HCPF shall consider the size of the facility and seriousness of the violation in setting the fine amount.

HCPF is to make the reported information and any corrective action plans for which fines were imposed available to the public.

Limitations on Collection Actions

Before assigning or selling patient debt to a collection agency or a debt collection buyer or pursuing any permissible extraordinary collection action:

- A facility must meet the screening requirements
- A facility and professional shall provide discounted care, or if the patient is not determined to be a "qualified patient", offer them a payment plan that does not exceed 5% of the patient's monthly household income

- Provide a plain language explanation of services and fees being billed and notify the patient of potential collection actions

A facility or professional that does not comply with the requirements of this section is liable to the patient in an amount equal to the sum of:

- Any actual damages sustained by the patient as a result of such failure to comply
- In the case of action brought by an individual, any additional damages that the court may allow, not exceeding \$1,000
- In the case of class action, such amount that the court may allow for class members without regard to a minimum individual recovery not to exceed the lesser of \$500,000 or 1% of the net worth of the facility or professional
- In the case of successful action to enforce liability, the costs of the action together with reasonable attorney fees, as determined by the court. On a finding by the court that the action was brought in bad faith, the court may award reasonable attorney fees to the defendant that are related to the work expended and costs

In determining the amount of liability in any individual action brought, the court shall consider, among other relevant factors, the frequency and persistence of noncompliance by the facility or professional, the nature of noncompliance, and the extent to which noncompliance was intentional.

Notification of Debt by a Health Care Provider

The bill adds the following definitions to existing statute regarding health care debt and notification.

Impermissible extraordinary collection action. Causing an individual's arrest, causing an individual to be subject to a writ of body attachment²⁰ or similar process, foreclosing on an individual's real property, or garnishing an individual's state income tax refund.

Medical creditor. A health care provider taking any collection activities or permissible extraordinary collection actions on an unpaid medical account on its own behalf. Any entity assigned an unpaid medical account by a provider in order to take collection action, which includes the provider's billing department, a business entity owned by the provider or a contracted collection business. It also includes any entity that has purchased an unpaid account and is taking collection actions on its own behalf.

Permissible extraordinary collection action. An action other than an impermissible extraordinary collection action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing a bank account or any other personal property, commencing civil action, or garnishing wages.

Limitations of Collections

Impermissible collection actions cannot be used by any creditor to collect debts owed for health services.

Permissible collection actions cannot occur until 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible collection action, a creditor shall provide the patient with a notice, to be developed by HCPF that contains the following:

- Statement that discounted care is available for qualified individuals and a plain-language summary of the discounted care policy and how to apply
- Statement of the permissible collection actions that will be initiated to obtain payment, and
- A deadline after which those collection actions will be initiated

If a creditor is collecting on a medical debt and it is later determined that the patient should have been screened for discounted care and is determined to be a qualified patient the creditor must reverse any collection actions including:

- Deleting any negative reports to consumer reporting agencies
- Dismissing any collection lawsuits over the medical debt and vacating any judgment

²⁰ A process issued by a court directing a law enforcement official to bring a person who has been found in civil contempt before the court.

- Removing any wage garnishment orders- if the patient has paid any part of the debt, or any of the patient's money has been seized/levied above the amount that they owe after applying the financial assistance must be refunded

A creditor collection on a medical debt shall not sell that debt to another entity unless the creditor has entered into a legally binding written agreement with the buyer that includes:

- The debt buyer or collector agrees not to pursue impermissible extraordinary collection actions
- The debt buyer cannot charge interest on the debt in excess of 8% per year²¹
- The debt is returnable to the creditor upon a determination that the patient is eligible for discounted care
- If the patient is determined to be eligible for discounted care and the debt is not returned, the debt buyer must adhere to procedures that ensure that the patient will not pay and has no obligation to pay more than what the patient is responsible for paying

This does not limit or affect the provider's right to pursue the collection of personal injury, liability, uninsured, underinsured, medical payment rehabilitation, disability, homeowner's, business owner's, worker's compensation, or fault-based insurance.

CICP Rules

HCPF is to promulgate rules for hospital providers under current CICP rules,²² which are approved by HCPF to participate in CICP and is a general hospital licensed by CDPHE and operates inpatient facilities. The rules are to prohibit hospitals from considering assets when determining whether a patient meets the program's specified percentage of the FPL and ensures the method for determining whether a patient meets the specified FPL is uniform across hospitals and aligned with the method for counting income to determine eligibility for discounted care.

Effective Date

The bill, subject to a petition, takes effect at 12:01am on the day following the expiration of the 90 day period after the final adjournment of the General Assembly.

Fiscal Note

The bill requires appropriation adjustments totaling \$181,182 to the Department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment.

The bill will increase expenditures in HCPF by \$230,625 and 1.0 FTE in FY 2021-22 and \$565,331 and 3.0 FTE in FY 2022-23. Staff is needed in FY 2021-22 to assist in rulemaking, develop an official statement of patient rights, develop a uniform screening application, and to begin compliance reviews on April 1, 2022.

The bill will decrease expenditures in the CDPHE by \$44,204 and 0.4 FTE beginning in FY 2021-22. In addition to a reduction in personal services, CDPHE will have a reduction of \$5,000 for a financial services consultant and \$10,000 to investigate hospital compliance.

Expenditures in the University of Colorado may increase to comply with the bill. If additional FTE are needed, the fiscal note assumes the health system will adjust current revenue sources to cover any additional expenditures affected by the bill. The bill may also affect revenue to these facilities in two main ways. First, it may limit revenue and debt collections from certain patients. Second, additional screening for public health insurance or the indigent care program may increase reimbursement for care provided.

²¹ C.R.S. § 5-12-101

²² 10 CCR 2505-10, SEC. 8.901.J

To the extent more civil cases are filed with the trial courts, workload in the Judicial Department will increase. The fiscal note assumes that the bill will not increase the number of cases to require additional FTE; therefore, no change in appropriation is required.

Reasons to Support

The bill would improve patient experience by establishing clear and consistent billing and collection practices across providers. It would assure that those with lower incomes gain access to programs providing discounted care. For services not covered by CACP, it would provide those with lower incomes discounts, limits on monthly billing, and write-offs after 3 years. It would likely reduce the number of patients sent to collections for receiving necessary health care, and may reduce medical bankruptcies. People who have put off care due to cost would be more likely to seek care, increasing their health status.

High medical debt can have long-term consequences, ruining credit, and fostering poverty. It also causes disproportionate harm to communities of color, further concentrating financial distress and higher uninsured rates in BIPOC communities.

Further, the state's COVID-19 recovery may be jeopardized if Coloradans are forced to avoid care or take on debt due to the cost of health care.

Supporters

- 9to5 Colorado
- AARP Colorado
- Bell Policy Center
- Center for Health Progress
- Chronic Care Collaborative
- Clayton Early Learning
- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Fiscal Institute
- Colorado Social Legislation Committee
- El Grupo Vida
- Family Voices Colorado
- League of Women Voters of Colorado
- Raise Coalition
- Spring Institute for Intercultural Learning
- Summit Family & Intercultural Resource Center
- The Consortium
- Towards Justice
- Women's Lobby of Colorado

Reasons to Oppose

This bill will create significant new administrative burdens for HCPF, and additional time and resources are likely to be needed. HCPF would need to develop, administer, and monitor new rules and regulations. They would need to develop and implement a complaint system, as well as the system to review facilities and professionals across the entire state. Writing patient rights in several different languages will be time-intensive and may cause HCPF to incur the cost of translation services. Additionally, the languages that are spoken by 10% or more of the population may change over time, so HCPF may also need to (1) periodically complete or obtain statewide surveys to determine which languages are fall under the required category and (2) create and disseminate completely updated patient rights resources as these linguistic/demographic changes occur.

The bill could create significant burdens on hospitals, outpatient facilities, and professionals in terms of increased administrative responsibilities and possibly lowered income. Administrative burdens on hospitals across Colorado would include (1) screening uninsured patients for health coverage options and potential financial assistance for which they may be eligible; (2) screening patients for coverage and assistance, offering them a fair payment plan and provide information regarding patient rights, before they can send a patient to collections; and (3) increasing state reporting requirements. Further, there is concern that the

determination of income for eligibility purposes would be very complicated for all types of facilities to accomplish and the process may not be uniform across facilities and systems, which would be unfair for consumers.

There may be financial burdens for facilities as services not included in CICP for those determined to be “qualified patients” would be reimbursed at 80% of Medicare rates, they would not be able to bill more than 5% of a household’s monthly income (which may be variable by month), and are required to write off all payments after 36 months, no matter how much of the bill has been paid. The financial burden is initially born by facilities and providers, and may be spread to those who are insured through higher charged rates. Rural hospitals are already struggling to stay afloat financially and to obtain/retain enough staff & providers - the burdens of this bill may push some rural facilities to close, exacerbating the shortage of health providers and facilities in rural areas of the state.

The requirement of ‘if the patient is not determined to be a “qualified patient”, they must be offered a payment plan that does not exceed 5% of the patient’s monthly household income’ before they are sent to collections seems to indicate that even those with incomes above 250% of FPL could be offered a payment plan that could last for years and may significantly impact the bottom lines of the providers.

The scope of facilities covered by this proposal is beyond just hospitals; including any outpatient facility that is affiliated with or operating under these hospitals or FSEDs, which could include all primary care and specialty clinics with any affiliation with a hospital, which may be the majority of clinics in any community. Most outpatient clinics likely do not have the current staff capacity to follow the requirements of the law and many not be able to accept 80% of Medicare rates and remain financially viable.

The write-off of all payments after 36 months could be a disincentive for people with income below 250% of FPL to acquire health insurance, if they knew that all financial obligations to pay an outstanding medical debt may eventually disappear.

Medicare does not cover all services (for example, dental or maternity care), so limiting charges to 80% of Medicare rates would sometimes prohibit providers from charging anything at all with the current proposed language.

Not taking any assets into consideration in determining income could mean that people who have very significant investments and bank accounts, but live off the interest, could remain uninsured, have very low payments to facilities and providers, and have their debt written off in 3 years, which likely shifts the financial burden to providers and insured patients.

The bill includes strong protections for consumers, but no protections for health services providers should a consumer commit fraud by not fully or accurately reporting income.

Opponents

- Colorado Chamber of Commerce
- Denver Metro Chamber of Commerce

Other Considerations

Would income be self-reported and verified by the hospital or outpatient facility or would health facilities be able to take advantage of the systems currently used by HCPF and the state government to verify income? Or would it just utilize the current system under CICP?

Should the provision requiring remaining debt to be cancelled after 36 months be removed from the bill?

Should the provision requiring facilities to provide a payment plan that does not exceed 5% of monthly income only be reserved for those deemed qualified patients by the screening process?

Suggest the use of language for what rate should be referenced and utilized when Medicare does not cover that service. Should that inclusion be in statute or done through rulemaking?

Groups Amending the Bill

- Associated Collection Agencies
- Colorado Hospital Association
- Denver Health
- HCA- The Healthcare Company
- SCL Health

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 analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.



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January 10, 2021

Board of Directors and Management
Health Services District of Northern Larimer County
Fort Collins, Colorado

We are engaged to audit the financial statements of the governmental activities and the major fund of Health Services District of Northern Larimer County as of and for the year ended December 31, 2020. Professional standards require that we communicate to you the following information related to our audit.

Our responsibility under Auditing Standards Generally Accepted in the United States of America

Our responsibilities, as described by professional standards, are as follows:

- Forming and expressing opinions about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America.
- Planning and performing the audit in accordance with auditing standards generally accepted in the United States of America to obtain reasonable, rather than absolute, assurance about whether the financial statements as a whole are free from material misstatement.
- Considering the entity's internal control over financial reporting as a basis for designing our audit procedures, but not to provide any assurance on the effectiveness of the entity's internal control over financial reporting.
- Communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters.
- Communicating matters required by law, regulation, agreement, or other requirements.

Our audit of the financial statements does not relieve you or management of your responsibilities.

With respect to the required supplementary information (RSI) accompanying the financial statements, we will make certain inquiries of management about the methods of preparing the RSI, including whether the RSI has been measured and presented in accordance with prescribed guidelines, whether the methods of measurement and preparation have been changed from the prior period and the reasons for any such changes, and whether there were any significant assumptions or interpretations underlying the measurement or presentation of the RSI. We will compare the RSI for consistency with management's responses to the foregoing inquiries, the basic financial statements, and other knowledge obtained during the audit of the basic financial statements. Because these limited procedures do not provide sufficient evidence, we will not express an opinion or provide any assurance on the RSI.

Our auditors' opinions, the audited financial statements, and the notes to financial statements should only be used in their entirety. Inclusion of the audited financial statements in a document you prepare, such as an annual report, should be done only with our prior approval and review of the document. Our responsibility for other information in documents containing the entity's financial statements and our auditors' report does not extend beyond the financial information identified in the report. We have no responsibility for determining whether such other information is properly stated and do not have an obligation to perform any procedures to corroborate other information contained in such documents. We are required by professional standards to read the other information in order to identify material inconsistencies between the audited financial statements and the other information because the credibility of the audited financial statements and our report may be undermined by material inconsistencies between the audited financial statements and other information.

Planned scope and timing of the audit

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit of the financial statements will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. We will generally communicate our significant findings at the conclusion of the audit. However, some matters may be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We expect to begin our audit on approximately March 23, 2021 and issue our report in May 2021.

Other planning matters

Recognizing the importance of two-way communication, we encourage you to provide us with information you consider relevant to the audit. This may include, but is not limited to, the following items:

- Your views about the following matters:
 - The appropriate person(s) in the entity's governance structure with whom we should communicate.
 - The allocation of responsibilities between those charged with governance and management.
 - The entity's objectives and strategies and the related business risks that may result in material misstatements.
 - Matters you believe warrant particular attention during the audit and any areas for which you request additional procedures to be undertaken.

- Significant communications with regulators.
- Other matters you believe are relevant to the audit of the financial statements.
- The attitudes, awareness, and actions of those charged with governance concerning (a) the entity's internal control and its importance in the entity, including how those charged with governance oversee the effectiveness of internal control, and (b) the detection or the possibility of fraud.
- The actions of those charged with governance in response to developments in law, accounting standards, corporate governance practices, and other related matters.
- The actions of those charged with governance in response to previous communications with the auditor.
- Your understanding of the risks of fraud and the controls in place to prevent and detect fraud, including your views on the following matters:
 - The “tone at the top” conveyed by management.
 - Programs and controls that the entity has established to mitigate identified fraud risks or that otherwise help to prevent, deter, and detect fraud.
 - How and how often you review the entity’s policies on fraud prevention and detection.
 - If a fraud hotline is in place, how it is monitored and how you are notified of allegations or concerns.
 - How you exercise oversight of management’s processes for identifying and responding to the risks of fraud and the programs and controls management has established to mitigate those risks.
 - The risks of fraud at the entity, including any specific fraud risks the entity has identified or account balances, classes of transactions, or disclosures for which a risk of fraud may be likely to exist.
 - Examples of fraud-related discussions management has had with you.
 - Any actual or suspected fraud affecting the entity that you are aware of, including measures taken to address the fraud.
 - Any allegations of fraud (e.g., received in communications from employees, former employees, analysts, regulators, short sellers, or others) that you are aware of.
 - Any accounting policies or procedures applied to smooth earnings, meet debt covenants, minimize taxes, or achieve budget, bonus, or other financial targets that you are aware of; and whether you are aware of any accounting policies that you consider aggressive.

- How you oversee the entity's (1) compliance with laws and regulations, (2) policies relative to the prevention of noncompliance and illegal acts, and (3) use of directives (for example, a code of ethics) and periodic representations obtained from management-level employees about compliance with laws and regulations.
- Whether you are aware of any noncompliance with laws and regulations, including measures taken to address the noncompliance.

* * *

This communication is intended solely for the information and use of the Board of Directors and management of Health Services District of Northern Larimer County and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

CliftonLarsonAllen LLP



Allison Slife, CPA
Principal
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