Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS SPECIAL MEETING

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

Tuesday, May 11, 2021
4:00 p.m.

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS SPECIAL MEETING
May 11, 2021
4:00 pm
Virtual

AGENDA

4:00 p.m. **Call to Order; Introductions; Approval of Agenda .....Michael Liggett**

4:05 p.m. **PUBLIC COMMENT**
Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

4:10 p.m. **DISCUSSION & ACTIONS**

- **Policy..... Alyson Williams**

  State Legislative Proposals
  - HB21-1258: Rapid Mental Health Response for Colorado Youth
  - HB21-1297: PBM (Pharmacy Benefit Manager) Transparency
  - SB21-137: Behavioral Health Recovery Act
  - SB21-158: Increase Medical Providers for Senior Citizens
  - SB21-018: Continuation of Necessary Document Program
  - HB21-1232: Standardized Health Benefit Plan Colorado Option

  Federal Policy Issues
  - American Families Plan
  - FDA Action on Menthol Tobacco

  Other policy issues that may arise

- **LETA: Continue Inclusion in Agreement?.....Carol Plock**

5:00 p.m. **DISCUSSION**

- **Timing:** ED Report, Equity Work Session; Board Retreat**.....Carol Pock**
- **Brief Status Update, COVID and the Health District.....Carol Plock**

5:10 p.m. **ANNOUNCEMENTS**

- **May 25, 4:00 pm – Board of Directors Regular Meeting**
- **June 22, 4:00 pm – Board of Directors Regular Meeting**
- **July 27, 4:00 pm – Board of Directors Regular Meeting**

5:15 p.m. **ADJOURN**

Join Zoom Meeting

Registration is required. Click this link to register:
https://healthdistrict.zoom.us/meeting/register/tJUqcO6prTkjGNXzL5Gtpwky3MUFs4LYX-4l

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

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB21-1258: Rapid Mental Health Response for Colorado Youth

Concerning establishing a temporary program to facilitate youth mental health services in response to identified needs, and, in connection therewith, making an appropriation.

Details

Bill Sponsors:	House – Michaelson Jenet (D) & Van Winkle (R) Senate – Buckner (D) & Woodward (R)
Committee:	House Public & Behavioral Health & Human Services House Appropriations Senate Health & Human Services
Bill History:	4/6/2021- Introduced in House 4/20/2021- House Public & Behavioral Health & Human Services Refer Amended to Appropriations 4/28/2021- House Appropriations Refer Unamended to House Committee of the Whole 4/28/2021- House Second Reading Passed with Amendments 4/29/2021- House Third Reading Passed-No Amendments 4/30/2021- Introduced in Senate
Next Action:	5/17/2021- Hearing in Senate Health & Human Services Committee

Bill Summary

The bill establishes a temporary Youth Mental Health Services Program within the Office of Behavioral Health to facilitate access to mental health services for youth to respond to identified mental health needs, including those resulting from the COVID-19 pandemic. The program reimburses provides for up to 3 mental health sessions. By July 1, 2021, a vendor has to be contracted with to create or use an existing website or application as a portal for both youth and providers to facilitate the program. The program is repealed June 30, 2022.

Issue Summary

Youth Mental Health Overview

Mental health is a crucial component of a child's overall health and shapes both physical and social well-being.[1] The Centers for Disease Control and Prevention (CDC) categorizes mentally healthy children as youth who learn appropriate social skills and coping mechanisms to approach difficulties, as well as those who attain emotional and developmental milestones.[2] Children who are mentally healthy have a favorable quality of life and function well at home, in school, and in their communities.[2]

Many children experience anxiety or display disruptive behaviors.[2] However, if these symptoms are persistent, severe or disrupt play, academic or home activities, the youth may be diagnosed with a mental disorder.[2] Up to 1 out of 5 children experience a mental health disorder each year, incurring an estimated $247 billion per year in costs to individuals, families and communities.[2] Half of all mental health conditions begin by age 14 and, if left untreated, can be detrimental to quality of life into adulthood and possibly lead

[1] American Psychological Association, "Children's Mental Health" 2009. https://www.apa.org/pi/families/children-mental-health
[2] Centers for Disease Control and Prevention (CDC), "Children's Mental Health", March 22, 2021. https://www.cdc.gov/childrensmentalhealth/basics.html

to suicide.[3] While less common, the rate of teen suicide has nearly doubled since 2010 in Colorado (2010: 11.5 per 100,000; 2019: 21 per 100,000).[4]

Mental disorders commonly diagnosed in youth are anxiety, depression, post-traumatic stress disorder (PTSD) attention-deficit/hyperactivity disorder (ADHD), and behavior disorders such as oppositional defiant disorder (ODD), conduct disorder (CD), Tourette syndrome, and obsessive-compulsive disorder (OCD).[2] Some children with a mental disorder may never be diagnosed, while others can be diagnosed at in early childhood or later in the teenage years.[2] In fact, 1 in 6 U.S. children aged 2–8 years (17.4%) had a diagnosed mental, behavioral, or developmental disorder.[5] The symptoms of mental disorders fluctuate as the child grows; consequently, early diagnosis and engagement of applicable services is key to maximizing treatment benefit for youth and their families.[2] Treatment rates vary among different mental disorders for youth. For children aged 3-17 with depression, 78.1% received treatment; however, for children with anxiety only 59.3% received treatment and 53.5% with behavior disorders received treatment.[5]

Impact of the COVID-19 Pandemic on Youth Mental Health[6]

The COVID-19 pandemic has exacerbated youth mental health conditions. Public health policies over the past year have required social distance to minimize spread of the virus. However, social distancing and other requirements to minimize community spread have also largely prevented social contact outside of the home. Schools closed and required children to learn from virtual classes and child care centers closed. Children were thus largely disconnected from social support systems and networks outside of their home and missed typical milestones – birthday parties, graduations, proms, etc., while also not being able to visit with family and loved ones. This social isolation and disruption caused youth significant emotional distress. Parents also faced a variety of challenges including being transitioned to work from home, subjected to higher risk of catching the virus as an essential worker, or lost their jobs due to the ensuing economic down-turn. The resulting caregiver stress, paired in some cases with the added loss of economic security and change in routine, compounded in some youth their anxiety, depression, and mental distress. Additionally, some youth may have been more exposed to child abuse and neglect, sexual violence and intimate partner violence at home. The transition of youth to virtual services and education in the effort to minimizing the spread of COVID-19, some children have been put at heightened risk.

State & Local Actions in Response to COVID-19

At the beginning of the pandemic, New Mexico Governor Michelle Lujan Grisham called on the state's Department of Children and Families to work with the Department of Human Services to continue provision of mental health services for children and youth.[7] Similarly, Michigan Governor Gretchen Whitmer required the schools in her state to continue mental health services for students.[8] State education agencies also took action to meet demand for student mental health care. The New Jersey State Board of Education modified its state administrative code to allow schools to provide counseling, among other typical student services via

[3] The World Health Organization, "Improving the mental and brain health of children and adolescents" 2021. https://www.who.int/activities/Improving-the-mental-and-brain-health-of-children-and-adolescents

[4] Kids Count Data Center, "Teen Suicides" 2020. https://datacenter.kidscount.org/data/tables/9851-teen-suicides-rate-per-100000?loc=7&loct=2#detailed/2/any/false/1729,37,871,870,573,869,36,868,867,133/any/19168,19169

[5] CDC, "Data and Statistics on Children's Mental Health. March 22, 2021. https://www.cdc.gov/childrensmentalhealth/data.html

[6] CDC "COVID-19 Parental Resources Kit – Childhood", December 28, 2020. https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/parental-resource-kit/childhood.html

[7] Office of the Governor Michelle Lujan Grisham, "Press Release: Governor: K-12 school closings must continue to prevent potential spread of COVID-19", Mar 27, 2020. https://www.governor.state.nm.us/2020/03/27/governor-k-12-school-closings-must-continue-to-prevent-potential-spread-of-covid-19/

[8] Office of Governor Gretchen Whitmer, "Governor Whitmer Signs Executive Order Suspending Face-to-Face Learning at K-12 Schools for Remainder of School Year", April 2, 2020. https://www.michigan.gov/whitmer/0,9309,7-387-90499_90640-524028--,00.html

telehealth[9]; likewise, the Texas Education Administration required remote provision of student services and counseling.[10]

More recently, states and specific school districts are actively responding to the increased demand for mental health services. Iowa Governor Kim Reynolds and the Iowa Department of Education allocated up to $8.67 million in competitive grants to (1) support youth mental health first aid training and implementation, (2) help pre-K-12 school districts coordinate and deliver mental health services and wraparound support to students, and (3) strengthen suicide prevention services and programming.[11] Additionally, Tennessee Governor Bill Lee re-introduced the Mental Health Trust Fund to assist K-12 families who are facing significant mental health issues in the wake of COVID-19. The proposed fund allocates $250 million to support direct clinical services in schools, mental health awareness and promotion, trauma-informed programs and practices, suicide prevention and postvention strategies, and mental health supports.[12] Arizona is also investing $21 million to hire 140 social workers and school counselors into the Arizona public school system, supplementing the School Safety Grant Program that integrated over 260 social and emotional support professionals into the school system. Additionally, the Arizona Department of Education will also utilize some of its federal recovery money to fully fund 69 school social worker and 71 school counselor positions across 10 counties for two years.[13]

Onondaga County, New York is investing $5 million to hire 100 more counselors for its schools and require each school to have an onsite mental health clinic.[14] Similarly, Atlanta Public Schools will invest a $1.95 million grant from the School-Based Healthcare Solutions Network to ensure licensed mental health providers are available in each of the district's schools starting next year.[15]

Health District CAYAC Program

The Child, Adolescent, and Young Adult Connections (CAYAC) Team was developed by the Health District of Northern Larimer County after an extensive planning process with parents/caregivers, our local school district, primary care providers, and health and human service organizations. CAYAC offers assessment and connection to the behavioral health treatment in the community best able to meet the particular needs of the child or youth. For a few years the CAYAC program was directly connected to a designated Poudre School District navigator. Working in partnership with a dedicated school behavioral health navigator, the team was able to identify the mental health needs of students early and prioritize those that needed immediate access to needs assessments and behavioral health screenings. Having the ability to provide assessments within the school increased student access to the right services in the community quickly and played a critical role in closing the communication loop between parents/caregivers, behavioral health providers, and teachers to best support student's needs. Due to funding cuts in 2018, our local school district was unable to maintain the in-house behavioral health navigator position and the team absorbed those duties. Referrals for needs

[9] State of New Jersey, Department of Education, "Notice of Rule Waiver/Modification/Suspension", March 9, 2020. https://www.nj.gov/education/sboe/meetings/agenda/2020/April/public/5d%20Item%20D%20Special%20Education%20revised.pdf

[10] National Conference of State Legislatures (NCSL), "Bridging the Gap to Youth Mental Health during COVID-19", April 17, 2020. https://www.ncsl.org/blog/2020/04/17/bridging-the-gap-to-youth-mental-health-during-covid-19.aspx

[11] KWQC TV6, "Gov. Reynolds announces $11.5M in mental health support for pre-K-12 schools. April 15, 2021. https://www.kwqc.com/2021/04/15/gov-reynolds-announces-115m-in-mental-health-support-for-pre-k-12-schools/

[12] Office of the Governor of Tennessee, Governor Lee Renews Proposal for Mental Health Trust Fund", March 29, 2021. https://www.tn.gov/governor/news/2021/3/29/governor-lee-renews-proposal-for-mental-health-trust-fund.html

[13] Azfamily.com, "Arizona Supt. of Education announces $21M for mental health resources in schools", April 19, 2021. https://www.azfamily.com/news/arizona_schools/arizona-supt-of-education-announces-21m-for-mental-health-resources-in-schools/article_355f8234-a14e-11eb-9b7b-a729cb8eb3ea.html

[14] WRVO Public Radio. Onondaga County to spend $5 million on mental health services in schools. March 29, 2021. https://www.wrvo.org/post/onondaga-county-spend-5-million-mental-health-services-schools#stream/0

[15] The Atlanta Journal-Constitution, "Atlanta Public Schools wins $1.95 million mental health services grant", April 8, 2021. https://www.ajc.com/news/atlanta-news/atlanta-public-schools-wins-195-million-mental-health-services-grant/XEMYZMTCARBQTL2KOI5WALLCBU/

assessments from schools dropped and it has taken more time from staff to outreach to schools and prioritize youth. It is much harder to prioritize youth for assessments and to bridge the information necessary to provide timely access to services. Additionally, the communication loop is harder to close between parents, providers, teachers, and school resource/support staff putting more students at risk of falling through the cracks.

This Legislation

Temporary Youth Mental Health Services Program

Portal. The website or web-based application that facilitates the program.

Program. The temporary youth mental health services program.

Provider. Licensed psychiatrist; licensed psychologist or psychologist candidate; licensed social worker, licensed clinical social worker or clinical social worker candidate; licensed marriage and family therapist or marriage and family therapist candidate; licensed professional counselor or licensed professional counselor candidate; or licensed addiction counselor or addiction counselor candidate.

Telehealth. Mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site.[16]

Youth. A person under the age of 18 or a person who is 21 or younger who is receiving special education services.

The program is established within the Office of Behavioral Health (OBH) to facilitate access to mental health services, including substance use disorder services, for youth to respond to mental health needs that are identified in an initial mental health screening through the portal, including needs that may have resulted from the COVID-19 pandemic. The program reimburses providers for up to three mental health sessions with a youth, either in-person or by telehealth. If there is available funds, providers may be reimbursed for additional sessions. To be eligible for reimbursement, the provider must be available to provide the three sessions to each youth accepted as a client by the provider. Providers are required to maintain client confidentiality pursuant to state or federal law.

OBH must develop a process for providers to apply for and demonstrate eligibility to receive reimbursement from the program. Additionally, OBH must determine a reasonable rate of reimbursement for each session, which must be the same regardless if the session is in-person or through telehealth. Finally, OBH must implement a statewide public awareness and outreach campaign about the program. OBH is encouraged to involve schools, neighborhood youth organizations, health care providers, faith-based organizations, and any other community-based organizations that interact with youth on the local level in disseminating information about the program.

The Department of Human Services (DHS) may promulgate rules to implement the program, including rules to protect the privacy of youth who receive services. By July 1, 2021, DHS must enter into an agreement with a vendor to create (or use an existing) website or application as a portal available to both youth and providers to facilitate the program. The selection of the vendor is exempt from the requirements of the state procurement code. The portal must:

- Serve as platform for initial age-appropriate mental health screenings to determine if a youth may benefit from mental health support
- Allow providers to register and share in-person or telehealth appointment availability

[16] C.R.S. § 10-16-123

- When possible, connect youth with providers who accept the youth's insurance or payment source that may cover the costs of ongoing mental health treatment, if the youth has such a third-party payer
- And allow a youth, regardless of coverage, to schedule telehealth appointments with a provider, an in-person appointment may be provided if and when available

By January 1, 2022, and by June 30, 2022, DHS shall report to the House Public and Behavioral Health and Human Services Committee and the Senate Health & Human Services Committee regarding the number of youth who received services under the program, excluding any personally identifiable information, information in aggregate about the services provided to youth under the program, and other relevant information regarding the program. The program is repealed June 30, 2022.

$9,000,000 is appropriated to DHS, for use by OBH to implement the program.

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

Reasons to Support

This bill is a key to addressing the huge mental health need across the youth of our state. Data from the CDC regarding youth treatment demonstrates that not all children are receiving help and schools can play a critical role in helping youth to care. Reports indicate there is a greater mental health need due to the pandemic. This bill would provide a preliminary screening and would assist in directing the

Supporters

- Adams County Regional Economic Partnership
- Aurora Mental Health Center
- Children's Hospital Colorado
- Colorado Alliance of Boys and Girls Clubs
- Colorado Behavioral Healthcare Council
- Colorado Children's Campaign
- Colorado Department of Human Services, Office of Behavioral Health
- Colorado Education Association
- Colorado League of Charter Schools
- Colorado Providers Association
- Colorado Psychiatric Society
- Colorado Psychological Association
- Colorado Rural Health Center
- Douglas County School District Parents of Students with Disabilities
- Education Reform Now Advocacy
- Envision:Youth
- Gazette Charities and Anschutz Foundation
- Jefferson Center for Mental Health
- Kempe Foundation for the Prevention and Treatment of Child Abuse
- Mental Health Colorado
- National Alliance on Mental Illness Colorado
- National Association of Social Workers, Colorado Chapter
- Stand for Children

Reasons to Oppose

This bill has a lot of unknowns, including how many kids need care out of a total of 883,199 total kids in the Colorado preschool through 12th grade system. Some assert that the timeline that is outlined in this bill is impossible to meet. Even if a youth is connected with a mental health professional that is within network, it does not ensure that they can have ongoing treatment as there may be coverage limitations, prior authorization requirements, or cost-sharing requirements that establish barriers to care. The bill does not clarify program accountability or reporting structures to see its effectiveness. Some believe that the funding allocated for this bill is not enough to execute the program that this bill outlines. School districts and students may be better served by investing in the mental health workforce for longer term sustainability and

accessibility for the youth. Youth dealing with significant issues that have been exacerbated by the pandemic may require more sessions as the first three sessions would likely be further evaluation and skill building, not really true therapy.

Opponents

- Community Reach Center

Other Considerations

- How will the program reach the kids who are English-second language learners, immigrant children, etc. in a culturally competent way?
- How will telehealth appointments be private if the children do not have a computer or internet access at home?
- Are there sufficient youth-focused providers to be able to provide access to all the youth that need care?
- Providers knowing if they have an option to expand from 3 to more sessions (based on available appropriations) will be critical for the therapeutic relationship and determining what the focus of the three therapy session is (i.e. does the provider just need to focus on skill building and stress management or can you focus on the increased depression and trauma that the child experienced?)

Organizations Amending

- Colorado Cross-Disability Coalition
- Colorado Hospital Association

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.

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB21-1297: Pharmacy Benefit Manager & Insurer Requirements

Concerning requirements regarding the administration of prescription drug benefits under health benefit plans.

Details

Bill Sponsors:	House – Hooton (D) Senate – Sonnenberg (D) & Buckner (D)
Committee:	House Health & Insurance
Bill History:	4/28/2021 – Introduced
Next Action:	5/11/2021- Hearing in House Health & Insurance
Fiscal Note:	May 3, 2021, no appropriation is required.

Bill Summary

The bill enacts the "Pharmacy Fairness Act", which imposes requirements regarding contracts between pharmacy benefit managers (PBMs) and pharmacies. The bill requires a health insurer or PBM to respond in real time to a request from an insured, their provider, or a third party acting on behalf of the insured or provider for data regarding the cost, benefits, and coverage under their plan for a particular drug. Further, the bill requires a health insurer or PBM that removes a prescription drug from the prescription drug formulary or moves it to a higher cost tier on the formulary during the benefit year to notify a covered person that is prescribed that drug at least 30 days before the action and allow the covered person to continue using the drug without prior authorization and at the same coverage level for the remainder of the benefit year, with some exceptions.

Issue Summary

Prescription Drugs

Among 11 Organization for Economic Cooperation and Development (OECD) countries, the United States (U.S.) has the highest pharmaceutical spending per capita at $1443, well above the mean of $749 for all 11 countries.[1] Retail pharmaceutical spending averages $541 per capita in these OECD countries, while U.S. spending on retail pharmaceuticals is almost double, at $1026 per capita.[1]

From 2017 until 2026 prescription drug spending is anticipated to increase 6.3 percent per year.[2] Out-of-pocket costs for patients was $82 billion in 2019, but each patient's exposure to these costs varied dramatically.[3] For example, only 1.1%, or 69 million prescriptions, cost more than $125 for the patient; however, these medicines bring a high burden to patients and can only be offset by coupons or vouchers in commercial plans.[3] Approximately 58% of Americans report that they are currently taking at least one prescription drug while 25 percent take four or more prescription drugs.[4]

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[1] Papanicolas I., Woskie L.R., & Jha AK. (2018). Health Care Spending in the United States and Other High-Income Countries. *JAMA,* 319(10):1024–1039. DOI:10.1001/jama.2018.1150

[2] Cuckler, G.A. et al. (2018). National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth. *Health Affairs, 37*(3). DOI: 10.1377/hlthaff.2017.1655

[3] IQVIA Institute for Human Data Science (Aug. 2020). *Medicine Spending and Affordability in the United States: Understanding Patients' Costs for Medicines.* Retrieved from https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-spending-and-affordability-in-the-us

[4] Henry J Kaiser Family Foundation (2018). *Public opinion on prescription drugs and their prices.* Retrieved from https://www.kff.org/slideshow/public-opinion-on-prescription-drugs-and-their-prices/

In 2019, 9% of all new prescriptions were abandoned at retail pharmacies.[5] Abandonment represents patient care that is recommended by a provider but not received. Abandonment rates are less than 5% when the prescription carries no out-of-pocket cost, but it rises to 45% when the cost is over $125 and 60% when the cost is over $500.[5]

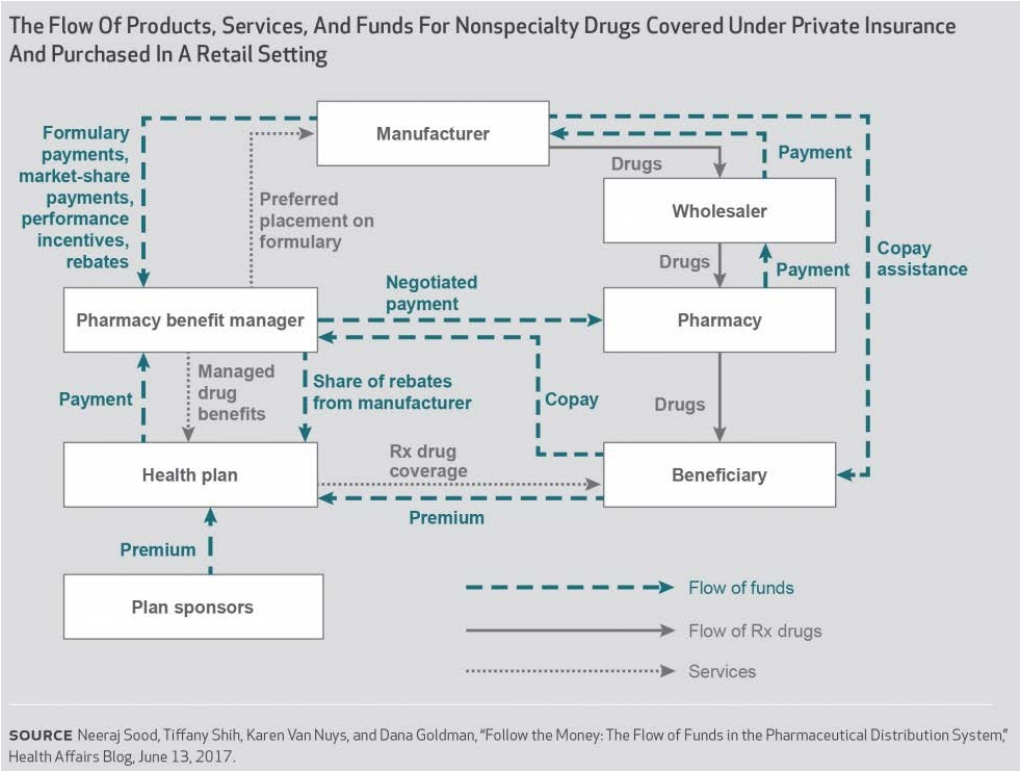
Prescription Drugs in Colorado

In 2019, more than 43.7 million prescription drugs were filled at pharmacies in Colorado, resulting in $6.74 billion of retail sales.[6] According to the Colorado Health Institute's (CHI) 2019 Colorado Health Access Survey, 10.8% of Coloradans cite the cost of prescription drugs as reason for not filling the medicines they are prescribed.[7]

In the 2019 Community Health Survey conducted by the Health District of Northern Larimer County, 55.1% of Larimer County residents reported taking or using more than one prescription drug at least once a week. Remaining consistent in comparison to the 2013 and 2016 Community Health Surveys, 9.7% of adult Larimer County residents reported being unable to have a prescription filled because they could not afford it during the preceding two years.[8] This rate is much higher among those who reported being uninsured (22.1%) and those who fell between 186 and 400 percent of the Federal Poverty Level (FPL)[9] (19.1%).

Supply Chain

The following graphic of the prescription drug supply chain illustrates the flow of payments and products through the system.



[5] IQVIA Institute for Human Data Science (Aug. 2020). *Medicine Spending and Affordability in the United States: Understanding Patients' Costs for Medicines.* Retrieved from https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-spending-and-affordability-in-the-us

[6] Henry J Kaiser Family Foundation (2020). *Health Costs & Budgets Indicators,* Retrieved from https://www.kff.org/state-category/health-costs-budgets/prescription-drugs/

[7] Colorado Health Institute [CHI] (2017). *Colorado Health Access Survey 2019: State of Colorado.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/State%20of%20Colorado_0.pdf

[8] With a 95% confidence interval ranging from 8% to 11.7%.

[9] The 2018 version of the Federal Poverty Level was utilized in the survey.

Pharmacy Benefit Managers (PBMs)

Pharmacy benefit managers (PBMs) can represent a variety of different types of health plans (i.e. private carriers, self-insured employers, union health plans, or government purchasers) in both the purchasing and distribution of pharmaceutical products.[10] Additionally, PBMs may design and administer pharmacy benefits for these payers.[11] PBMs can influence what products are utilized and set the rates that pharmacies are reimbursed for their services in the supply chain. Essentially, PBMs are the broker between the payers, drug manufacturers, and pharmacies. Due to the variety of roles PBMs perform, these entities play a central role in the pharmaceutical market.

In 2016, more than 266 million individuals, approximately 82% of the U.S. population, received their pharmacy benefits through PBMs.[12] With the volume of the clients they serve, they can leverage those numbers to negotiate rebates and other discounts from manufacturers. Three PBMs, Express Scripts, CVS Health, and OptumRx, control two-thirds of the market share in the U.S.[13] Rebates to PBMs from manufacturers have increased in previous years and are estimated to have contributed to lower net prices for drugs and decreased expected drug spending growth in 2017.[14] Not only do PBMs create these relationships with manufacturers, but they also create networks of pharmacies.

PBMs typically generate revenue through five main sources: manufacturer rebates, generic pricing spreads, formulary design, fees from clients, and fees/shared savings from pharmacy networks. It is important to note that although it is difficult to analyze PBMs profitability, price negotiations are opaque by design.[15] First, manufacturers offer rebates based on how much the PBM has the capacity to increase their market share; however, the PBM is not required to share the actual amount of these rebates with health plans.[11] Therefore, the PBM can keep some or all of the funds received through rebates.[11] Second, since the maximum allowable cost (MAC)[16] price lists for generic medicines are a range of prices, a PBM can negotiate with manufacturers for a lower price and then use the lower MAC price to reimburse pharmacies but charge insurers the higher MAC price.[11] The PBM can pocket the money from this spread in pricing. Third, PBMs can amplify the financial benefits of the previous two strategies by designing their formularies intentionally.[11] Due to the previous two profit strategies, a PBM has an incentive to promote a less cost-efficient drug over another drug that is more cost-efficient because it may get a better rebate for the less cost-efficient drug.[11] Fourth, PBMs receive fees from their clients for the administration of claims relating to the payer's pharmacy benefit and the dispensing of the drugs.[15] Finally, through the maintenance of their network of pharmacies PBMs receive fees and some of the savings that have been realized at that level.[11]

Many PBMs are beginning to operate their own mail-order pharmacies. For example, the mail order pharmacies for Express Scripts and CVS make up 20 percent of the market for retail pharmacies in the U.S.[13] These mail-order pharmacies are an opportunity for greater revenue as it can maximize generic pricing spreads and manufacturer rebates.[11] It is estimated that in 2016, the gross profits for PBMs were $22.6 billion.[17]

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[10] Health Affairs (Sept. 2017). *Prescription Drug Pricing: Pharmacy Benefit Managers.* Retrieved from http://www.healthaffairs.org/healthpolicybriefs

[11] Meador, M. (2011). Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry through Regulation, *Annals of Health Law, 20*(1). Retrieved from https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1045&context=annals

[12] Pharmaceutical Care Management Association (May 18, 2018). Pharmacy Benefit Managers (PBMs). *Presentation to National Conference of State Legislatures.* Retrieved from http://www.ncsl.org/Portals/1/Documents/Taskforces/PharmacyCostsPBMs-PCMA_Presentation_31397.pdf

[13] Sood, N., Shih, T., Van Nuys, K., & Goldman, D. (June 2017). The Flow of Money through the Pharmaceutical Distribution System. *USC Leonard D. Schaeffer Center for Health Policy & Economics*. Retrieved from http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf

[14] Cuckler, G.A. et al. (2018). National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth. *Health Affairs, 37*(3). DOI: 10.1377/hlthaff.2017.1655

[15] Health Affairs (Sept. 2017). *Prescription Drug Pricing: Pharmacy Benefit Managers.* Retrieved from http://www.healthaffairs.org/healthpolicybriefs

[16] The MAC is the price list for generic drugs; there is no one standard MAC, but rather a range of acceptable prices.

[17] Yu, N.L., Atteberry, P., & Bach, P.B. (July 31, 2018) *Spending on Prescription Drugs in the US: Where Does All the Money Go?* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20180726.670593/full/

Private Insurance Companies

A health insurance carrier or their contract PBM creates a formulary for specific health plans to detail a list of covered drugs. A formulary is a list of drugs developed by a committee within the carrier or PBM utilizing evidence-based medicine and the judgment of experts. When creating this list, the decision-making committee considers and reviews clinical literature, information from the FDA, current therapeutic use, economic data, and provider recommendations.[18]

The primary purpose of a formulary is to encourage patients to access the most effective and affordable medications available. Frequently, this formulary is combined with a system of tiers to create incentive-based formularies.[19] The tier correlates to the level of coverage that will be provided. Typically, the most cost-effective or least expensive drugs are assigned to a preferred tier and have the lowest cost sharing requirements for the patient.[19] Most insurers place a higher copay on branded drugs in order to discourage their use and steer covered members towards purchasing a bioequivalent generic.[20] How the tiers are structured and whether non-preferred drugs are included in the tiers depends on the plan and the carrier. The first tier tends to be generics and possibly some select brand-name drugs, which are the least expensive drugs covered by a plan. Within the second tier are what are known as preferred drugs, or brand name drugs that have been chosen by the committee for the formulary, and tend to be a little more expensive than tier one drugs. The third tier, which may or may not be included in a plan's formulary, are the non-preferred drugs. Finally, the final tier typically includes most specialty drugs and the most expensive. Some insurers may place a drug on a high cost sharing tier to place pressure on the manufacturer to lower the cost; however this can have a financial burden on consumers, lower adherence, and penalize those that do not respond to cheaper alternatives.

A plan's formulary may change during the course of a plan year as new drugs are added, pricing fluctuates, utilization of drugs changes, or medical knowledge transforms.[21] These changes can include removing a drug from the formulary, increasing cost-sharing, changing the tier of the drug, or altering the utilization management criteria (i.e. prior authorizations or step therapy).[21] This mid-year formulary change does not initiate a special enrollment period for the consumer; therefore, they may be stuck in a health plan that no longer meets their needs.[21] Some consumers may be able to have access to their medications through an exception process, but many consumers are not aware that this process exists and the plan may not grant an exception.[21]

Of the total national health expenditures on retail prescription drugs, 42% was by private insurance.[22] Furthermore, retail drugs comprised 21% of employer health benefits in 2017.[22] The design of pharmacy benefits is getting more complex, as illustrated by the fact that 83% of individuals with employer-sponsored health insurance have benefits that have three or more tiers of cost sharing.[23] Among those covered workers with three or more tiers- the average copayments are $11 for first-tier drugs, $35 second-tier drugs, $62 for third-tier drugs, and $116 for fourth-tier drugs. Additionally, some employer-sponsored plans require individuals to meet a deductible before specialty drugs, such as biologics, are covered. Furthermore, the plan can require a separate deductible before any prescription drug is covered.

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[18] Academy of Managed Care Pharmacy (Nov. 2009). *Formulary Management.* Retrieved from http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=9298

[19] Goldman, D.P., Joyce, G.F., & Zheng, Y. (July 2007). Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health. *JAMA,* 298(1). DOI: 10.1001/jama.298.1.61

[20] Dafny, L., Ody, C., & Schmitt, M. (Oct. 2016) When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. Retrieved from https://www.nber.org/system/files/working_papers/w22745/w22745.pdf

[21] Consumer Representatives of the National Association of Insurance Commissioners [NAIC] (Aug. 2016). *Promoting Access to Affordable Prescription Drugs: Policy Analysis and Consumer Recommendations for State Policymakers, Consumer Advocates, and Health Care Stakeholders.* Retrieved from https://consumersunion.org/wp-content/uploads/2016/08/Promoting-Access-to-Affordable-Prescription-Drugs_Aug-2016.pdf

[22] Kamal, R., Cox, C. & McDermott, D. (Feb. 20, 2019) *What are the recent and forecasted trends in prescription drug spending?.* Retrieved from https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/

[23] Kaiser Family Foundation (Oct. 2020). *2020 Employer Health Benefits Survey: Section 9 Prescription Drug Benefits.* Retrieved from https://www.kff.org/report-section/ehbs-2020-section-9-prescription-drug-benefits/

This Legislation

Definitions

Pharmacy benefit management firm, pharmacy benefit manager, or PBM. Any entity doing business in Colorado that administers or manages prescription drug benefits, including claims processing services and other prescription drug or device services, on behalf of any insurance carrier that provides prescription drug benefits to Coloradans, either by contract with the carrier or as an entity that is related/associated to or has common ownership with the carrier. A PBM does not include a CDPHE licensed/certified health facility, a provider, a consultant who only provides advice regarding the selection or performance of a PBM, or a nonprofit health maintenance organization (HMO) that offers managed care plans that provide a majority of covered professional services through a single contracted medical group and that operates its own pharmacies.

Pharmacy Fairness Act

Claims processing services. Administrative services performed in connection with processing and adjudicating claims related to pharmacist services, which includes receiving payments for pharmacist services or making payments to pharmacies or pharmacists for pharmacist services.
Other prescription drug or device services. Services, others than claims processing, provided directly or indirectly and either in connection with or separate from claims processing. These services include managing or participating in incentive programs or arrangements for pharmacist services; negotiating or entering into contractual agreements with pharmacies or pharmacists; developing formularies; designing prescription drug benefit programs, and advertising or promoting services.
PBM-affiliated pharmacy. A pharmacy or pharmacist that, either directly or indirectly through one or more intermediaries, owns or controls or is owned or controlled by a PBM.
PBM network. A network of pharmacies or pharmacists that are offered an agreement or contract to provider pharmacist services for a health plan.
Pharmacist services. Products, foods, and services provided as a part of the practice of pharmacy.[24]
Starting in 2022, each carrier is to submit to the Commissioner of Insurance, along with its required rate filings and in a manner specified through rulemaking, a list of all PBMs that carrier uses for services. The list is considered proprietary and is not subject to disclosure under the Colorado Open Records Act (CORA).

Starting in 2022, a PBM or its representative must not preclude covered individuals from accessing prescription drug benefits under their plan at an in-network retail pharmacy unless the FDA has restricted the distribution of the drug or it requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. A plan may impose a different cost sharing amount for obtaining a drug at a retail pharmacy, but all cost sharing must count towards the plan's annual out-of-pocket maximum and must be account for in the plan's actuarial value. A PBM or its representative shall not charge a pharmacy/pharmacist a fee related to the adjudication of a pharmacist services claim, other than a one-time reasonable fee, not to exceed the lesser of 25% of the dispensing fee or 25 cents, for receipt and processing of that claim. Additionally, the PBM shall not require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements to similarly situated PCM-affiliated pharmacies within the same network. The PBM is prohibited from failing or refusing to designate a pharmacy as 'preferred' that is located in a county with a population of 20,000 or less.

A PBM that administers the drug assistance program operated by the department of public health and environment is exempt from the requirements and prohibitions of the act with regard to the PBM's administration of that program only.

[24] C.R.S. § 12-280-103(39)

PBM Audit of Pharmacies

Except under certain circumstances, a PBM, carrier, or an entity acting on behalf of those entities shall not conduct an on-site audit of a pharmacy that has had an on-site audit within the immediately preceding 12 months.

Real-time Access to Benefit Information & Formularies

CMS. Federal Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.

Cost sharing information. The amount a covered person is required to pay for a drug that is covered under their health plan.

Covered or coverage. Health care services to which a covered person is entitled under the terms of the covered person's health plan.

Drug. Any prescription drug or medication covered under a health benefit plan, whether ordered, prescribed, or administered.

Healthcare common procedure coding system. The system developed by CMS for identifying health care services in a consistent and standardized manner.

National drug code. The unique, three-segment identifier number used by the FDA to identify drugs that are manufactured, prepared, propagated, compounded, or processed for sale in the United States.

Third party. A person other than a PBM that is not an enrollee or a covered person under a health plan.

Upon request of a covered person, their provider, or a third party on behalf of the person or provider, a carrier or their PBM must furnish the cost, benefit, and coverage data to them. The carrier or PBM must ensure that the data is current and updated no later than one business day after any change is made, provided in real time, and provided in the same format that the request was made. The person, provider, or third party shall submit the request and the carrier or PBM shall respond to it using the established industry content the transport standards published by:

- A standards-developing organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, the Accredited Standards Committee, or Health Level Seven International
- Or a relevant federal or state governing body, including the Centers for Medicare and Medicaid Services (CMS) or the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health & Human Services (HHS)

A fax, proprietary payer or patient portal, or other electronic form is not an acceptable electronic format. Upon receipt of the request, the PBM or carrier must provide the following data for any covered drug for their plan:

- The person's eligibility information for the drug
- A list of any clinically appropriate alternatives to the drug that are covered
- Cost sharing information for the drug and for clinically appropriate alternatives, including a description of any variance in cost sharing based on pharmacy, whether retail or mail, or provider dispensing or administering the drug
- Any applicable utilization management requirements for the drug or alternatives, including prior authorization, step therapy, quantity limits, and site-of-service restrictions

The carrier or PBM must provide this data whether the request is made using the drug's billing code (National Drug Code or Healthcare Common Procedure Coding System code) or a descriptive term, such as the brand or generic name of the drug. Additionally, they must not restrict, prohibit, or otherwise hinder a provider from communicating or sharing with the covered person any of the requested data, any additional information on any lower-cost or clinically appropriate alternatives or additional information that may reduce the person's out-of-pocket costs, such as cash price or patient assistance programs. PBMs and carriers cannot interfere with or materially discourage access, exchange, or use the data including: charging fees, failing to respond to a request, implement technology in nonstandard ways, substantially increase the

complexity or burden of access, exchanging or using the data, or penalizing a provider for disclosing information or prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

Starting in 2022, if a carrier or a PBM during the benefit year removes coverage of a prescription drug on the formulary or moves the drug to a higher cost tier, the carrier or PBM is required to:

- Notify a person who has been prescribed the drug electronically or in writing (if requested by the covered person) and at least 30 days before removing or moving the drug in the formulary
- Allow a covered person to whom the drug has been prescribed to continue to use the drug for the remainder of the benefit year without prior authorization and at the same coverage applied before the drug was removed or moved

Nothing precludes a carrier or PBM from removing a drug from the formulary in the following circumstances:

- Due to safety issues raised by the FDA, the drug manufacturer, or the carrier/PBM
- If the manufacturer has notified the FDA of a manufacturing discontinuance or possible discontinuance
- If the manufacturer has removed the drug from the market

If a carrier or PBM removes a drug from the formulary for one of these reasons the entity must notify a covered person who has been prescribed that drug of its removal as soon as practicable after the event giving rise to the removal occurs.

Severability

If any provision of the bill is judged invalid, it does not affect the provisions that can continue to occur without the invalid provision.

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 bill increases workload in the Department of Regulatory Agencies and has an indeterminate, though likely minimal, impact on state agencies that work with PBMs. Local governments may experience a fiscal impact to the extent that costs for PBM contracts change.

Reasons to Support

The rising cost of prescription drugs requires some to pay exorbitant amounts of money out of pocket to receive a drug or others may opt to go without the drug if a formulary is changed in the middle of a plan year. The bill could provide assurances to consumers that their health plan will maintain coverage for those drugs that they need throughout the course of the plan year. The bill aims to ensure patients and providers have quick access to the cost of prescription drugs.

Supporters

- Arthritis Foundation
- Chronic Care Collaborative
- Colorado Cross-Disability Coalition
- Colorado Organization Responding to AIDS
- McKesson Corporation
- Rocky Mountain Cancer Centers

Reasons to Oppose

Allowing carriers and PBMs to make changes to the prescription drug formulary allows for them to account for the increasing cost of some prescription drugs. Some assert that this bill is likely to result in higher health insurance premiums as the carriers and PBMs would have to continue covering drugs at the same level even

if there is a dramatic price increase from the manufacturer. Additionally, the requirements may be viewed as an obstruction to developing strategies for overall cost-savings.

Opponents

- America's Health Insurance Plans
- Colorado Association of Health Plans
- Colorado Competitive Council
- CVS Health

Other Considerations

How would the carrier or PBM be able to know exactly what a pharmacy would charge the patient, especially if the patient's cost sharing requirements are coinsurance and the price the patient pays is based off of the pharmacy's charges?

What does it mean that the response needs to be in the same format as the request when the bill states that "A fax, proprietary payer or patient portal, or other electronic form is not an acceptable electronic format"? Does that mean that a patient or provider cannot email the carrier/PBM and receive an email in return? Additionally, does that mean a patient couldn't use a mobile application from the carrier/PBM to request the real time information and get a response via that mobile application?

Amending Organizations

- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Community Health Network

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.

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

SB21-137: BEHAVIORAL HEALTH RECOVERY ACT

Concerning the "Behavioral Health Recovery Act of 2021", and, in connection therewith, making an appropriation.

Details

Bill Sponsors:	Senate – Pettersen (D) House – Michaelson Jenet (D) & Kennedy (D)
Committee:	Senate Health & Human Services Senate Appropriations
Bill History:	3/1/2021- Introduced in Senate 3/31/2021- Senate Health & Human Services, Testimony/Committee Discussion Only 4/5/2021- Senate Health & Human Services Refer Amended to Appropriations 4/30/2021- Senate Appropriations Refer Amended to Senate Committee of the Whole
Next Action:	5/7/2021- Senate Second Reading
Fiscal Note:	April 27, 2021, For FY 2021-22, the bill includes appropriations of $22.0 million and requires additional appropriations of $12.9 million to multiple state agencies.

Bill Summary

This bill concerns a variety of issues and programs related to behavioral health and substance use. In part, this bill would restore funding to certain behavioral health programs that received a reduction in funding during the 2020 legislative session due to the budgetary impact of the pandemic.

Issue Summary

Opioid Prescribing

Nationally, the opioid prescribing rate has decreased from 81.3 per 100 persons in 2012 to 46.7 per 100 persons in 2019.[1] Although the prescribing amount, Morphine Milligram Equivalents (MME)[2], has decreased nationally in the past few years to 640 MME per capita, it is still substantially above the 180 MME per capita that was measured in 1999.[3]

In 2019, the opioid prescribing rate in Colorado was 40 per 100 people, which has decreased from 73.5 prescriptions per 100 people in 2012.[1] State-specific research by the Colorado Department of Public Health and Environment (CDHPE) delineated that the number of opioid prescriptions per person increased with age.[4] One quarter of Coloradans have admitted to using pain medications in ways that were not prescribed by their provider.[5] Similarly, 29 percent of Coloradans have use pain medications that were not prescribed to them.[5] In Larimer County, the prescribing rate has dropped from 84.2 prescriptions per 100 people in 2012 to 52.7 prescriptions per 100 people in 2017.[17]

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[1] CDC (Dec. 2020). *U.S. Opioid Dispending Rate Maps.* Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[2] Morphine Milligram Equivalents is a value that is assigned to opioids to represent their relative potency to provide for the ease of comparison.

[3] Guy GP Jr., Zhang K, Bohm MK, et al.(July 2017). Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. *MMWR Morb Mortal Wkly Rep 2017*;66:697–704. doi: http://dx.doi.org/10.15585/mmwr.mm6626a4

[4] Colorado Department of Public Health and Environment (July 2017). *Colorado Prescription Drug Profile.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Colorado%20Rx%20Drug%20Data%20Profile.pdf

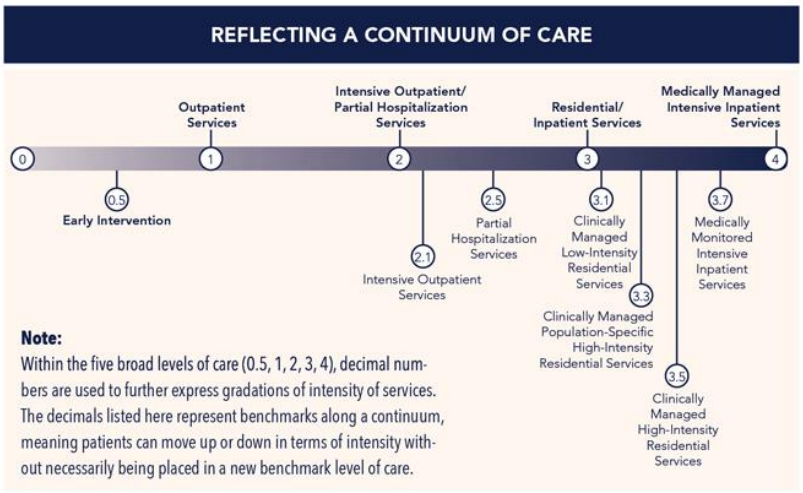
[5] Colorado Chapter of the American College of Emergency Physicians (2017). *2017 Opioid Prescribing and Treatment Guidelines: Confronting the Opioid Epidemic in Colorado's Emergency Departments.* Retrieved from http://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf

The Centers for Disease Control and Prevention (CDC) promulgated guidelines regarding the prescription of opioids in 2016.[6,7] The CDC recommended that when prescribing opioids for acute pain it should be sufficient to prescribe a quantity for three or less days, and rarely for more than seven. That should be adequate to address the expected duration of pain severe enough to require opioids while decreasing the risk of long-term use. Furthermore, the guidelines suggest that the use of a PDMP can ensure that the patient is not taking any other opioids or could have a negative interaction between two prescriptions.

The Colorado Department of Health Care Policy and Financing (HCPF) has implemented rules for the Colorado Medicaid program that limited an initial opioid prescription to a 7-day supply and limited refills, with prior authorization required after four refills.[8] Additionally, HCPF limited dosages of opioids to a certain threshold (200 MME per day) for pain management and anything above that MME requires prior authorization.

ASAM Criteria

The figure to the right illustrates the American Society of Addiction Medicine's (ASAM) listing of the continuum of levels of care necessary in order to be able to refer a person to the level of care appropriate for their particular need.[9] Services in the continuum range from the least intensive interventions on the left (Early Intervention, Outpatient, and Intensive Outpatient Services), to the most intensive interventions on the right (Partial Hospitalization, Residential, and Inpatient Services). When critically important service levels are missing, a community lacks the tools needed to give a person experiencing substance use disorder the best evidence-based chance of recovery.



Medication-Assisted Treatment (MAT)

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines medication-assisted treatment (MAT) as medications utilized with counseling and behavioral therapies to treat substance use disorders and to prevent opioid overdose.[10] Currently, there are three classes of medications that that have been approved by the Food and Drug Administration (FDA) to treat opioid use disorders: methadone, buprenorphine, and naltrexone.[11] Methadone is an opioid agonist that reduces the symptoms of opioid withdrawal while blocking the euphoric effects of most opioids, including heroin. Methadone is required to

[6] Dowell D., Haegerich T.M., Chou R. (2016) *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*. MMWR Recommendation Report; 65(No. RR-1):1–49.doi: http://dx.doi.org/10.15585/mmwr.rr6501e1
[7] CDC (2021). *About CDC's Opioid Prescribing Guideline.* Retrieved from https://www.cdc.gov/drugoverdose/prescribing/guideline.html
[8] HCPF (July 24, 2019) *Health First Colorado Initiatives Cut Opioid Use More than 50 Percent.* Retrieved from https://www.colorado.gov/pacific/hcpf/news/health-first-colorado-initiatives-cut-opioid-use-more-50-percent
[9] ASAM Continuum (May 13, 2015). *What are the ASAM Levels of Care?* Retrieved from https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/
[10] Substance Abuse and Mental Health Services Administration (2015). *Medication and Counseling Treatment.* Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat
[11] California Health Care Foundation (Sept. 2017). *Why Health Plans Should Go to the "MAT" in the Fight Against Opioid Addiction.* Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-Why-Health-Plans-Should-Go-to-the-MAT.pdf

be administered daily in an office setting for the first few years of maintenance treatment. Federal rules require methadone to be prescribed and dispensed by a certified Opioid Treatment Program. Buprenorphine is an opioid partial agonist that can reduce the effects of withdrawal but it produces effects such as euphoria or respiratory depression. Since buprenorphine has these effects it is often produced in combination with naloxone to reduce the potential for misuse. [12] With naltrexone, an opioid antagonist, the medication blocks both the euphoric and sedative effects of opioids; additionally, a patient is to abstain from opioids for 7-10 days for beginning the medication. Injectable naltrexone must be administered in a health care setting by a licensed provider, which includes pharmacists. Naltrexone can also be utilized to treat alcohol use disorders (AUD). Studies have shown the effectiveness of naltrexone in decreasing cravings and improving outcomes.[13,14] The following table demonstrates the regulations and effectiveness for the three FDA-approved medications. [15]

Table 1. Medications Used in Addiction Treatment

	WHERE IT CAN BE PROVIDED	FDA INDICATIONS	EFFECTIVENESS*	ADMINISTRATION
Methadone	**OUD.** Licensed opioid treatment programs. **Pain.** Any Drug Enforcement Agency (DEA)-licensed prescriber.	OUD and pain management	74% to 80%[12]	**OUD.** Daily pill, liquid, and wafer forms; injectable form in hospitalized patients unable to take oral medications **Pain.** Pill and injectable forms
Buprenorphine and buprenorphine/ naloxone	Prescribed by community physicians and dispensed by pharmacies; available in some opioid treatment programs. Physicians receive federal waivers after eight hours of training; nurse practitioners and physician assistants require 24 hours. Patient panels are capped at 30, 100, and 275 per provider (depending on experience and setting).[13-15] Any DEA-licensed provider can prescribe buprenorphine for pain.	OUD and pain management (depending on formulation and dose)	60% to 90%[16]	**OUD.** Daily sublingual, buccal, film, and tablet, or six-month intradermal device **Pain.** Injectable, transdermal, and buccal film
Naltrexone	No restrictions.	Opioid and alcohol use disorders	**OUD.** 10% to 21%[17]	Daily pill or monthly injectable
Naloxone (used only for overdose reversal, not addiction treatment)	Any setting: prescribed or dispensed by a clinician, furnished by a pharmacy without a prescription (legal in several states), dispensed by lay staff in community settings (by standing order), or carried by law enforcement or other first responders.	To reverse respiratory suppression in suspected opioid overdose	May require high doses for extremely high-potency illicit drug use (e.g., fentanyl and carfentanyl)	Intranasal spray, or intravenous, intramuscular, or subcutaneous injectable

*Retention in treatment at 12 months with significant reduction or elimination of illicit drug use.

Evidence has demonstrated the effectiveness of MAT, yet only 10 percent of those that seek this treatment can access it in the United States.[2] The barriers can range from a shortage of buprenorphine prescribers[16], to restrictive health plans, to stigma. Since methadone can only be administered by a certified Opioid Treatment Program, this places yet another barrier to treatment for patients. Insurance barriers can include dosage limits, authorization requirements, inadequate counseling coverage, cost-sharing requirements, and

[12] Substance Abuse and Mental Health Services Administration (2015). *Medication and Counseling Treatment.* Retrieved from https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

[13] Anton, R.F. (May 3, 2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *JAMA. 295*(17). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16670409

[14] Helstrom, A.W. (Sept. 2016). Reductions in Alcohol Craving Following Naltrexone Treatment for Heavy Drinking, *Alcohol and Alcoholism 51*(5). Retrieved from https://academic.oup.com/alcalc/article/51/5/562/1740449

[15] Note that the acronym OUD included in the figure stands for opioid use disorder.

[16] Office of Inspector General, U.S. HHS (Jan 2020). *Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder.* Retrieved from https://oig.hhs.gov/oei/reports/oei-12-17-00240.asp

"fail-first" criteria.[17] Furthermore, the reimbursement rates from both public and private insurance carriers to pharmacists for administration of injectable naltrexone is less than that received by other providers for the same action. These insurance barriers can even delay an individual's care; a 2017 survey by the California Society of Addiction Medicine found that 41 percent of member providers had experienced situations where patients went without treatment due to authorization delays.[2]

Treatment in Colorado

In 2019, there were 43,731 treatment admissions for substance use disorder in Colorado, 276 more admissions than in the previous year.[18] Alcohol is the substance with the largest number of treatment admissions, a trend that has continued since 2009. Heroin treatment admissions have increased by 52 percent since 2015 while methamphetamine admissions have increased by 31 percent. Nearly half of treatment admissions (42%) were for heroin or meth.

The Colorado Health Institute's (CHI) 2017 report for HCPF detailed many aspects about the landscape of residential and inpatient treatment within the state.[19] From 2010 to 2014, approximately 10.9% of Coloradans who needed treatment for an alcohol use disorder (AUD) received it while 15.7% of those with an illicit SUD received needed treatment. Approximately 67,000 Coloradans needed treatment but did not receive it, with the rates being higher among Medicaid recipients than privately insured individuals. More than half of respondents (54.1%) to CHI's Community Health Access Survey (CHAS) reported not getting the treatment they need due to cost. Similarly, 52.8% responded that they did not think their insurance would cover the treatment services.

Alcohol or Substance Exposure in Children

Prenatal exposure to substances, including alcohol, has the potential to cause a variety of physical and developmental issues. In the United States, it is estimated that 15% of infants are affected by prenatal alcohol or illicit drug exposure.[20] Data from Colorado's *Pregnancy Risk Assessment Monitoring System* documents the use of alcohol during pregnancy as well as health care worker and patient interactions about the subject during prenatal care.[21] In 2016, 17.3% of pregnant women reported consuming alcohol during the last 3 months of their pregnancy, up from 12% in 2015. Only 67.8% of respondents said that their health care worker talked about how drinking alcohol could affect baby, while 57.8% said that they talked about how using illegal drugs could affect the baby.

Behavioral Health During Pregnancy and the Postpartum Period

Mental health is a central component during the postpartum period. In the past ten years, suicidality has risen among pregnant and postpartum individuals.[22] One in ten individuals experience perinatal depression, with higher rates and lower access to treatment for BIPOC individuals and those with low-incomes.[23] Due to

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[17] "Fail-First" can require detox before medication coverage or failure of another medication before coverage is allowed.

[18] Substance Abuse Trend and Response Task Force (Jan. 2021) *Annual Report.* Retrieved from https://coag.gov/app/uploads/2020/12/2021-Annual-Report-Substance-Abuse-Trend-Response-Task-Force.pdf

[19] Colorado Health Institute (2017). *Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf .

[20] National Center on Substance Abuse and Child Welfare (n.d.) *Infants with Prenatal Substance Exposure.* Retrieved from https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx

[21] Colorado Department of Public Health and Environment. *CO Health and Environmental Data.* Retrieved from https://www.cohealthdata.dphe.state.co.us/

[22] Admon LK, Dalton VK, Kolenic GE, et al. Trends in Suicidality 1 Year Before and After Birth Among Commercially Insured Childbearing Individuals in the United States, 2006-2017. *JAMA Psychiatry.* 2021;78(2):171–176. doi:10.1001/jamapsychiatry.2020.3550. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2772882?utm_source=STAT+Newsletters&utm_campaign=97fadf08d3-MR_COPY_01&utm_medium=email&utm_term=0_8cab1d7961-97fadf08d3-149539289&appId=scweb

[23] Kaiser Family Foundation. (March 9, 2021). *Expanding Postpartum Medicaid Coverage.* Retrieved from https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/

the complexity of mental health in the postpartum period, the American College of Obstetricians and Gynecologists (ACOG) recommends screening during the initial postpartum visit and referral to treatment.[24] The American Academy of Pediatrics recommends integrating postpartum depression surveillance and screening at the 1-, 2-, 4-, and 6-month visits for the parent's child.[25] Treatment for mental health in the postpartum period can provided over a long duration, which often last beyond 60 days. The most common single cause of maternal death from 2014-2016 was suicide.[26] The Colorado Maternal Mortality Review Committee developed the following recommendations for the state:

- Integrate universal screening and connection to treatment for mental health conditions and substance use disorders into maternity care.
- Improve opioid prescribing practices.

Housing

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness. The approach is guided by the principle that an individual needs a basic necessity like housing before they can address other issues like a substance use disorder, obtaining a job, or learning how to budget.[27] The housing in this approach is intended to be permanent but the types of housing provided varies by program. Services that are provided include screening, needs assessment, housing assistance, support services, case management, and sometimes on-site medical or behavioral health care.[28] In this approach SUD services are usually offered, although abstinence and/or treatment are not required for participation. A study found that individuals with SUD report less housing stability that those without a SUD. It further found that participants in the Housing First group were 17 times more likely than those in a "treatment as usual" group to report sustained housing and high scores on community functioning.[29] It is important to note that all types of SUDs do not respond the same to the Housing First model; one study has shown that stimulant users, such as cocaine, have somewhat less successful housing outcomes than individuals with other SUDs.[30]

Harm Reduction Grant Program

The purpose of the program is to "reduce health risks associated with drug use and improve coordination between law enforcement agencies, public health agencies, and community-based organizations."[31] CDPHE administers the program and the current recipients are: Boulder County Public Health Department, Harm Reduction Action Center, Lakewood Police Department, Pitkin County Public Health, and Southern Colorado Harm Reduction Association.[32]

[24] ACOG (Nov. 2018). *Screening for Perinatal Depression.* Retrieved from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression?utm_source=redirect&utm_medium=web&utm_campaign=otn

[25] American Academy of Pediatrics (2020). *Maternal Depression.* Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Maternal-Depression.aspx

[26] Colorado Department of Public Health and Environment (2020). *Colorado Maternal Mortality Prevention Program Legislative Report 2014–2016*. Retrieved from https://drive.google.com/file/d/11sB0qnM1DmfCA-Z87el3KMHN6oBy5t2y/view

[27] National Alliance to End Homelessness (Apr. 2016). *Fact Sheet: Housing First.* Retrieved from http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf

[28] Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing first for homeless persons with active addiction: are we overreaching?. *The Milbank quarterly*, *87*(2), 495-534.

[29] Division of Addiction, Cambridge Health Alliance (Jan. 24, 2018). *Substance Use: Housing First or treatment as usual?* Retrieved from https://www.basisonline.org/2018/01/stash-vol-14-1-substance-use-housing-stability.html

[30] Edens, E.L., Tsai, J., & Rosenheck, R.A. (2014). Does stimulant use impair housing outcomes in low-demand supportive housing for

[31] C.R.S. §25-20.5-1101

[32] CDPHE (2021). *Overdose Prevention.* Retrieved from https://cdphe.colorado.gov/overdose-prevention

Colorado AgrAbility

The Colorado AgrAbility Project is a collaboration between Colorado State University Extension and Goodwill Industries of Denver and is a part of the National AgrAbility Project.[33] The project currently promotes success in agriculture for people with disabilities or other physical challenges and their families.

This Legislation

Podiatrist Opioid Prescribing Limits

The current limitations on opioid prescribing for podiatrists that were enacted with the passage of SB18-022[34] are continued in perpetuity instead of being repealed on September 1, 2021.

Medication Assisted Treatment Expansion Pilot Program

The bill extends the Medication Assisted Treatment Expansion Pilot Program for an additional year, through June 30, 2024. For state fiscal years 2020-21 through 2023-24 the General Assembly shall annually appropriate $3 million.

Colorado AgrAbility Project

The General Assembly finds that the Colorado AgrAbility project should expand through providing more funding for rural rehabilitation specialists. Colorado State University (CSU) is to implement the project, in cooperation with the federal government.[35] The project is to be expanded by providing rural rehabilitation specialists with funding to provide information, services, and research-based, stress-assistance information, education, suicide prevention training, and referrals to behavioral health services to farmers, ranchers, agricultural workers, and their families. For the 2021-22 state fiscal year, and each fiscal year thereafter, $900,000 shall be annually appropriated to CSU for the project. Nothing in the section prevents CSU from complying with federal requirements so CSU can qualify for federal funds.

Community Prevention & Intervention

For the 2021-22 state fiscal year, and each fiscal year thereafter, the General Assembly shall appropriate $2 million to CDPHE to address behavioral health disorders through prevention and intervention and work with community partners, including local public health agencies. CDPHE can use the funding for data collection, analysis, and dissemination related to behavioral health disorders at the state and local levels. This includes community health assessments and improvement planning. Of the appropriation, CDPHE may use up to $500,000 for administrative costs and other related activities.

Harm Reduction Grant Program Appropriations

The bill makes the grant program funds continuously appropriated to CDPHE instead of being subject to annual appropriation. Additionally, the bill repeals current statute language that requires the state Treasurer to transfer all unexpended and unencumbered money in the fund to the state General Fund on September 1, 2024.

Medicaid Managed Care Organization Authorization

A Medicaid managed care organization (MCO) is to notify a person's provider of approval of authorization of residential, inpatient, or medical detoxification services no later than 24 hours after the request is submitted. The initial authorization for intensive residential treatment must be for a period of no less than 7 days and it must be no less than 14 days for transitional residential treatment. However, if an MCO does not have sufficient documentation from the provider, the initial authorization can be less. An MCO is to

[33] Colorado State University (n.d.) *Colorado AgrAbility Project.* Retrieved from https://agrability.agsci.colostate.edu/

[34] SB18-022 instituted opioid prescribing limits on dentists, physicians, physician assistants, advanced practice nurses with prescriptive authority, optometrists, podiatrists, and veterinarians.

[35] Food, Agriculture, Conservation, and Trade Act of 1990, as amended

continually authorize services in accordance with the provider if the MCO's determination conflicts with the provider's recommendation. The MCO can request additional information the rationale for continued treatment. An MCO must provide specific justification for each denial of continued authorization for all six dimensions in the most recent edition of the ASAM Criteria.

Screening for Perinatal Mood & Anxiety Disorders

For the parent of each child enrolled in Colorado's Medicaid program, the program must include screening for perinatal mood and anxiety disorders in accordance with HRSA guidelines. The screening must be made available to any person, even if they are not enrolled in Medicaid, so long as their child is enrolled.

Statewide Data Collection & Information System

By January 1, 2023, the Department of Human Services (DHS) is to develop a statewide data collection and information system to analyze implementation data and selected outcomes to identify areas for improvement, promote accountability, and provide insights to continually improve child and program outcomes in the Early Childhood Mental Health Consultation Program. The system and related process must place the least burden possible on the program's mental health consultants. In selecting the implementation data and outcomes, DHS must incorporate the variability across diverse settings and populations. In 2023, and every two years after, must incorporate in its hearing to the Joint Budget Committee (JBC) and its January 2027 SMART Act[36] hearing a report of the following issues. The report must include a gap analysis of the available number of mental health consultants and the unmet need in the various settings where they practice in the program as well as identified adjustments to better meet caseload, with DHS identifying a target number of consultants needed in the program. By August 1, 2026, DHS shall contract with an independent third party to conduct an evaluation of the program and its impact on early childhood and program outcomes across the state. The evaluation results must also be presented at the January 2027 SMART Act hearing for DHS.

DHS and HCPF must explore funding options for the program and improve access to mental health consultants, including the Colorado Health Plan Plus (CHP+) and Medicaid. By January 1, 2023, the two departments are to report to the JBC any identified funding options.

Behavioral Health Service Vouchers in Rural/Frontier Communities

No later than 180 days after the bill's effective date, DHS, in collaboration with the Department of Agriculture, shall contract with a nonprofit that focuses on serving agricultural and rural communities to provide vouchers to individuals living in rural and frontier communities in need of behavioral health services. The awarded nonprofit is to contract with licensed behavioral health providers that have completed cultural competency training to provide direct behavioral health services to farmers, ranchers, workers, their families, and other underserved populations in rural and agricultural communities. At least 60% of the money received from the contract must be used on direct services. The nonprofit also must develop training materials to train those providers on cultural competencies specific to Colorado's agricultural and rural community. For state fiscal year 2021-22, and each fiscal year thereafter, the General Assembly shall annually appropriate $50,000 for the awarded contract.

Center for Research into SUD Prevention, Treatment, and Recovery Support Strategies ('the Center')

The bill expands the role of the Center to include engaging community engagement activities to address substance use prevention, harm reduction, criminal justice system response, treatment, and recovery. For the 2021-22 state fiscal year, and each year after, $750,000 is to be appropriated to the Center from the Marijuana Tax Cash Fund.

[36] Enacted 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.

Building SUD Treatment Capacity in Underserved Communities Grant Program

The program will no longer be repealed on July 1, 2024.

Perinatal Substance Use Data Linkage Project

Currently, statute allows the perinatal substance use data linkage project to consider state-administered data sources. The bill requires the project to utilize data from Medicaid, the prescription drug monitoring program (PDMP), the Colorado TRAILS system, the Colorado Immunization Information System (CIIS), the Colorado Child Care Assistance Program (CCCAP), the Office of Behavioral Health (OBH), and the birth and death records. Additionally, the project can connect additional state and non-state data sources to improve population-level estimates of perinatal substance exposure and examining system utilization and outcomes. The bill updates the reporting requirement to be an annual requirement.

Recovery Residence Certifying Body

By January 1, 2022, OBH shall use a competitive selection process pursuant to the state procurement code to select a recovery residence certifying body. The certifying body is to certify recovery residences as well as educate and train recovery resident owners and staff on industry best practices. For state fiscal year 2021-22, and each fiscal year after, the General Assembly must appropriate $200,000 to OBH to implement this section.

Temporary Financial Housing Assistance

OBH must establish a program to provide temporary financial housing assistance to individuals with a substance use disorder who have no supportive housing options when the person is either transition out of residential treatment into recovery or is currently receiving treatment. OBH can promulgate rules to establish a maximum for the financial assistance that an individual can receive as well as the maximum time period for that assistance. Rules regarding time maximums must be clinically based. In awarding assistance, OBH must consider funding for individuals entering a recovery residence.

By February 1, 2022, and each February 1 after, OBH must submit a report that details the amount of assistance provided in the previous year, the number of entities and individuals that received assistance, and the duration of assistance. The report is submitted to the Senate Health and Human Services Committee, the House Health and Insurance Committee, the House Public and Behavioral Health and Human Services Committee, and the Opioid and Other Substance Use Disorders Study Committee. For state fiscal year 2021-22, and each fiscal year after, the General Assembly must appropriate $4 million to OBH for the housing assistance program.

Recovery Support Services Grant Program

Grant program. The recovery support services grant program.

Recovery community organization. An independent, nonprofit organization led and governed by representatives of local communities of recovery that organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, or provide peer-run recovery support services.

The grant program is created in OBH to provide grants to recovery community organizations to provide recovery-oriented services to individuals with a substance use disorder or co-occurring substance use and mental health disorder. A grant recipient can use the funds for the following purposes:

- Offer opportunities for individuals with a substance use disorder or co-occurring substance use and mental health disorder to engage in activities focused on mental or physical wellness or community service

- Provide guidance to individuals with a substance use disorder or co-occurring substance use and mental health disorder and their family members on navigating treatment, social service, and recovery support systems
- Help individuals with a substance use disorder or co-occurring substance use and mental health disorder to connect with resources needed to initiate and maintain recovery as outline by SAMHSA's four dimensions of recovery: health, home, community, and purpose
- Assist in establishing and sustaining a social and physical environment supportive of recovery
- Provide local and state recovery resources to recovery organization participants and community members, and
- Provide recovery support services for caregivers and families of individuals recovering from a substance use and co-occurring mental health disorder

OBH administers the grant program and disburses appropriated grant funds to each managed service organization (MSO). OBH must promulgate rules necessary to implement the grant program. To receive a grant, a recovery community organization must submit an application to the applicable MSO, in accordance with OBH rules. Each MSO reviews the applications, and awarding grants, the MSO shall prioritize an applicant who outlines the capacity to deliver recovery support services to meet the needs of diverse racial, cultural, income, ability, and other underserved groups.

By December 1, 2023, and each December 1 after, each MSO that awards grants must submit a report to OBH, which at a minimum includes the following:

- The number of community members involved in the recovery community organization
- A detailed description of the organization's advocacy efforts
- Any collaborative projects a recovery community organization has with other such organizations across the state
- Any other information required by OBH

By March 1, 2022, and each March 1 after for the duration of the grant program, OBH must submit a summarized report to the Senate Health and Human Services Committee, the House Health and Insurance Committee, the House Public and Behavioral Health and Human Services Committee, and the Opioid and Other Substance Use Disorders Study Committee.

For state fiscal year 2021-22 and each fiscal year after, the General Assembly must appropriate $1.6 million from the General Fund to OBH in order to implement the grant program. OBH can use a portion of the funds for direct and indirect costs of administering the program.

Maternal and Child Health Pilot Program

Currently, statute only authorizes appropriations for the implementation of the pilot program from state fiscal year 2019-20 through 2021-22. The bill expands it to be in perpetuity.

Public Awareness of Opioids and Opiate Antagonists

The bill removes the scheduled repeal of the program to increase public awareness concerning the safe use, storage, and disposal of opioids and the availability of naloxone and other drugs used to block the effects of an opioid overdose.

Opioid Treatment for Incarcerated Individuals

The bill adds language to current statute regarding treatment for people in the custody of facilities under the supervision of the Department of Corrections (DOC). As funding and supplies allow, a person in custody who is being treated for an opioid use disorder while in custody is released, the facility or prison must offer at

least two doses of an opioid reversal medication upon their release. The person must also be provided education about the appropriate use of the medication. This does not impose civil or criminal liability when ordinary care is used in the administration or provision of the reversal medication when the person appears to be experiencing an overdose.

Safe Station

The bill removes language that names fire stations as safe stations. Therefore, only policy and county sheriff's offices/stations are named as safe stations.

Definition of Substance Use Disorder

The bill updates the definition of a substance use disorder to be "a chronic relapsing brain disease, characterized by recurrent use of alcohol, drugs, or both, causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Appropriations

For state fiscal year 2021-22 $500,000 is appropriated to the Department of Education (CDE) from the General Fund to be used for the Behavioral Health Care Professional Matching Grant Program.

For state fiscal year 2021-22 $2.5 million is appropriated to CDE from the Marijuana Tax Cash Fund to be used for the K-5 Social and Emotional Health Pilot Program.

For state fiscal year 2021-22 the following funding is appropriated to OBH from the General Fund:

- $3.530 million to MSOs for SUD treatment recovery providers for unanticipated expenses related to COVID-19
- $3.25 million for community mental health centers for unanticipated expenses related to COVID-19
- $500,000 directed to MSOs for Screening, Brief Intervention, Referral to Treatment (SBIRT), training, and supports
- $2 million for services provided to school-age children and parents by community mental health center school-based clinicians and prevention specialists
- $3.8 million for co-responder programs, Colorado crisis system services, housing assistance, transition specialist programs, and treatment for rural communities
- $2 million for behavioral health and SUD treatment for children, youth, and their families
- $250,000 for treatment and detoxification programs
- $500,000 for community transition services for guardianship services for individuals transitioning out of mental health institutes
- $75,000 for the perinatal substance use data linkage project

For state fiscal year 2021-22 the following funding is appropriated to CDPHE from the General Fund:

- $250,000 for allocation to mental health first aid for in-person and virtual trainings
- $1.15 for the opiate antagonist bulk purchase fund and school-based health centers
- $500,000 for the Colorado HIV and AIDS prevention grant program

For state fiscal year 2021-22 $500,000 is appropriated to DHS from the General Fund for the early childhood mental health consultation program.

For state fiscal year 2021-22 $600,000 is appropriated to the Department of Higher Education from the General Fund for the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies to use for health provider education, grant writing assistance, and personal protective equipment and telehealth supplies for the MAT expansion program.

For state fiscal year 2021-22 $120,000 is appropriated to the Department of Law from the General Fund for the Safe2Tell program.

Effective Date

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

Reasons to Support

As Colorado recovers from the impacts of the pandemic, it is more important than ever to ensure access to the behavioral support and services they need to thrive.

Supporters assert that reducing opioid prescribing will also reduce the quantity of drugs available for misuse and abuse. Creating this limit will reduce the chance that the development of an opioid use disorder will develop in opioid naïve patients. Additionally, it decreases the possibility that excess opioid pills fall into the hands of someone other than the intended patient.

Research emphasizes that substance use disorders are legitimate disorders of the brain, that require a full continuum of care (including, but not limited to, MAT and long term recovery residences) in order to give the individual the best chance of recovery. Larimer County has a strong interest in assuring that there are quality recovery residences (that allow continuation of MAT) in our community, in order to have the full continuum of care required for those with substance use disorders. Although funding for the residences themselves was not included in the planning for the recent county ballot initiative, 1A, which was passed to expand access to mental health services, funding for the continuance of SUD counseling and services for people in the residences was included. The funding for temporary financial housing assistance to individuals with SUDs who are in recovery or transition is critically important for those individuals' recovery success.

Having increased funding for vouchers for those who need housing and have a behavioral health condition is a major need in Larimer County. Affordable housing is incredibly hard to find- and far more difficult for those with mental illness or SUD, who require the stability in order to manage their conditions. For those coming out of state-run institutions, assuring a healthy environment rather than a return to homelessness or to a previously unhealthy environment can help maintain health and stability, and avoid future interactions with local and state health and human services and the criminal justice system.

This bill would help align Colorado's Medicaid reimbursement policy with national guidelines to help ensure Colorado parents are getting the mental and behavioral health care they need.

Supporters

- Boulder County
- Children's Hospital Colorado
- Colorado Association of Local Public Health Officials
- Colorado Association for School-Based Health Care
- Colorado Behavioral Healthcare Council
- Colorado Children's Campaign
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Criminal Justice Reform Coalition
- Colorado Cross-Disability Coalition
- Colorado Farm Bureau
- Colorado Hospital Association
- Colorado Nurses Association
- Colorado Providers Association
- Colorado Psychiatric Society
- Colorado Society of School Psychologists
- Colorado State University
- Counties & Commissioners Acting Together (CCAT)
- Emergent Biosolutions
- Envision:You

- Illuminate Colorado
- Jefferson Center for Mental Health
- Mental Health Colorado
- National Alliance on Mental Illness Colorado
- National Association of Social Workers, Colorado Chapter
- Native Roots Cannabis
- University of Colorado

Reasons to Oppose

Some believe that policies that aggressively limit prescription opioid prescribing could drive people to turn to illicit drugs and injection opioids, such as heroin. Some assert that too strict of opioid prescribing limits could force patients to live with inadequately treated pain, which could lead to other physical and behavioral health issues for the patient. A CDC analysis found that chronic pain may be an important contributor to suicide.[37] Other opponents may assert that this is an intrusion into the provider-patient relationship and the practice of medicine.

Opponents

- Any opposition has not been made public at this time.

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.

[37] Petrosky E, Harpaz R, Fowler KA, et al. (2018) Chronic Pain Among Suicide Decedents, 2003 to 2014: Findings From the National Violent Death Reporting System. *Ann Intern Med*.169:448–455. doi: https://doi.org/10.7326/M18-0830 Retrieved from https://annals.org/aim/fullarticle/2702061/chronic-pain-among-suicide-decedents-2003-2014-findings-from-national

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: IDA COSSITT-GLESNER POLICY BRIEF

SB21-158: Increase Medical Providers for Senior Citizens

Concerning modification to the Colorado health service corps program administered by the department of public health and environment to expand the availability of geriatric care providers in shortage areas in the state.

Details

Bill Sponsors:	Senate – Danielson (D) and Pettersen (D) House – Titone (D) and Duran (D)
Committee:	Senate Health & Human Services Senate Appropriations
Bill History:	3/1/2021- Introduced in Senate 3/22/2021- Senate Health & Human Services Refer Amended to Appropriations
Next Action:	Hearing in Senate Appropriations
Fiscal Note:	March 18, 2021, For state fiscal year 2021-22 the bill requires an appropriation of $225,000 to CDPHE.

Bill Summary

The bill modifies the Colorado Health Service Corps program administered by the Primary Care Office in the Department of Public Health and Environment (CDPHE) to allow geriatric advanced practice providers, which include advanced practice registered nurses and physician assistants with geriatric training or experience, to participate in the loan repayment program on the condition of committing to provide geriatric care to older adults in health professional shortage areas for at least two years. The bill adds a physician who provides geriatric care or a geriatric advanced practice provider to the Colorado Health Services Corps Advisory Council. The bill requires the General Assembly to appropriate money from the General Fund to CDPHE for the purpose of helping repay loans for geriatric advanced practice providers through 2025-26. The requirement is repealed on September 30, 2026. The following amounts are required:

- State fiscal year (FY) 2021-22: $225,000
- FY 2022-23: $400,000
- FY 2023-24: $575,000
- FY 2024-25: $450,000
- FY 2025-26: $275,000

Issue Summary

Shortage of Geriatric Service Providers

The American population is aging. Since 2010, about 10,000 Americans have turned 65 each day, and by 2030 all baby boomers will be 65 or older. Since the beginning of the 20th century, the percentage of Americans over 65 has more than tripled, increasing from 4.1% in 1900 to 15.2% in 2016[1]. The number of individuals above 65 years old is predicted to increase 55% by 2030[2] and older adults are expected to outnumber children for the first time in the nation's history by 2034[1]. With such a large demographic shift, the country's medical professional community must adapt to serve the specialized needs of seniors and know how to help seniors thrive physically and emotionally.

[1] National Conference of State Legislatures, "Finding Long-Term Solutions for Long-Term Care", March 2021. https://www.ncsl.org/research/health/finding-long-term-solutions-for-long-term-care.aspx

[2] Petriceks, A. Olivas, J., & Srivastava, S. Gerontology and Geriatric Medicine (May 18, 2018). Trends in Geriatrics Graduate Medical Education Programs and Positions, 2001 to 2018. https://doi.org/10.1177%2F2333721418777659

Geriatric providers are physicians who specialize in illness care for older people, utilizing a holistic approach of patient well-being across their team of providers.[3] Approximately 30% of people 65 years and older would best be served by the services of a geriatrician, and a single geriatrician can care for up to 700 seniors.[3] In 2018, the older adult population totaled 49.2 million, while there were only 6,796 certified geriatricians and only 3,590 were practicing full-time.[3] The aging U.S. population is generating significant demand for geriatric medical providers and there are not enough providers to meet that demand. From 2013 to 2025, the demand for geriatric providers is projected to grow by 45%.[3] Similarly, a 2020 study revealed that the geriatric workforce capacity decreased from 10,270 in 2000 to 8,502 in 2010.[4] Additionally, between academic years 2001-2002 and 2017-2018, geriatrics-related graduate medical education programs expanded by only 1.1%, while the geriatrics workforce shrunk by 23.3%.[2] Researchers recommend several avenues to addressing the U.S.'s growing shortage of geriatric providers – increasing the number of geriatric experts, providing geriatric training for the entire health workforce, and improving outreach and education of older adults and their caregivers about their available resources.[3]

Geriatrics Workforce Shortage in Colorado5

Colorado suffered from a shortage of geriatric medical providers before the COVID-19 pandemic. The pandemic has made it even more difficult to meet geriatric medical needs across the state. In Colorado, over 38% of the state's COVID deaths have been residents of long-term care facilities. Providing the same level of medical care was difficult for many reasons , including the need for medical providers to quarantine after exposures and the need to take time off to address child care needs. Over the past year, 25% of the state's nursing homes had a shortage of nurses and medical aides and this significantly undermined the quality of care delivered to elderly patients. Even though COVID vaccination rates are rising in Colorado, many long-term care facilities in the state are still struggling with shortages of nurses, certified nursing assistants, and medical assistants.

Colorado Health Service Corps

The Colorado Health Service Corps (CHSC) utilizes financial incentivizes to expand the supply of medical providers in fields and communities where they are most needed. Under the program, primary care providers working in designated health professional shortage areas (HPSAs) (e.g. the fields of mental health, primary care and dental care, and in medically underserved areas and populations) can apply to receive funding to repay qualifying educational loans.[6] Loans must be federal and/or private commercial loans taken out for education and related expenses directly related to the provider's medical field.[7]

Through the Colorado Health Service Corps, medical professionals must provide direct clinical care.[8] To participate in CHSC, medical professionals must be one of the following: Doctors of allopathic or osteopathic medicine (geriatrics, general psychiatry, general child psychiatry, family medicine, general internal medicine, general pediatrics, addiction medicine or pain management, general obstetrics and gynecology); licensed clinical or counseling psychologists; licensed professional counselors; licensed clinical social workers; licensed marriage and family therapists; certified nurse-midwives; nurse practitioners; advanced practice nurses with specific training in substance use disorders or pain management; physician assistants; physician

[3] American Geriatrics Society, "Geriatrics Workforce By the Numbers", 2021. https://www.americangeriatrics.org/geriatrics-profession/about-geriatrics/geriatrics-workforce-numbers

[4] Lester PE, Dharmarajan TS, Weinstein E. The Looming Geriatrician Shortage: Ramifications and Solutions. J Aging Health. 2020 Oct;32(9):1052-1062. doi: 10.1177/0898264319879325. Epub 2019 Oct 4. PMID: 31583940.

[5] Fox21 News, "Staffing Shortages at Colorado Long-Term Care Facilities Worsened by the Pandemic", March 11, 2021. https://www.fox21news.com/health/coronavirus/staffing-shortages-at-colorado-long-term-care-facilities-worsened-by-the-pandemic/

[6] Colorado Department of Public Health and Environment, "Colorado Health Service Corps", 2021. https://cdphe.colorado.gov/colorado-health-service-corps

[7] Colorado Department of Public Health and Environment, "Colorado Health Service Corps Eligibility Details", 2021. https://cdphe.colorado.gov/colorado-health-service-corps-eligibility-details

[8] Colorado Department of Public Health and Environment, "Colorado Health Service Corps Prospective Applicants", 2021. https://cdphe.colorado.gov/prevention-and-wellness/health-access/colorado-health-service-corps/colorado-health-service-corps-0

assistants with specific training in substance use disorders; psychiatric nurse specialists; dentists; registered dental hygienists[9]; licensed addiction counselors; and certified addiction counselors.[8]

CHSC providers must agree to work full-time or part-time and maintain the required number of clinical contact hours.[9] Providers are awarded according to their profession and time commitment. CHSC participating providers are required to work at qualifying clinics that treat underserved patients.[10] Such clinics must accept patients on public insurance, such as the Children's Health Plan Plus (CHP+), Medicare, or Medicaid; offer a sliding fee scale based on income and family size for those at or below 200% of the Federal Poverty Level (FPL); and accept all patients regardless of ability to pay.[10] Eligible clinic types include free clinics, rural health clinics, school-based clinics, community-funded safety-net clinics, public correctional facilities, state mental health hospitals, tribal health clinics, federally qualified health centers, and hospital-associated outpatient clinics.[10]

Reasons to Support

This bill will make it more financially appealing for medical students to specialize in geriatrics and for those medical providers to stay in Colorado once they graduate. Adding a geriatric physician or advanced practice provider to the Colorado Health Services Corps Advisory Council will ensure geriatric medical provision remains a priority of the CHSC program moving forward. Such an addition will also likely facilitate a legislative motion to renew the funding that this bill creates, once the funding of this bill expire.

Supporters

- AARP
- Alzheimer's Association of Colorado
- Archdiocese of Denver
- Boulder County
- Colorado Catholic Conference
- Colorado Center on Law & Policy
- Denver Regional Council of Governments
- Leading Age Colorado
- University of Colorado

Reasons to Oppose

This bill places additional requirements on the state's limited General Fund and competes with more demands for state funding in the immediate recovery from COVID-19.

Opponents

- Any opposition has not been made public at this time.

Monitoring or Neutral

- Aveanna – Formerly PSA HealthCare
- Colorado Association of Medical Equipment Services (CAMES)
- Colorado Behavioral Healthcare Council
- Colorado Dental Association
- Centura Health
- Colorado Hospital Association
- Colorado Radiological Society
- Colorado Rural Health Center
- Colorado Society of Anesthesiologists
- Colorado Society of Anesthesiology
- Hope West Colorado
- Vivage Quality Health Partners

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

[9] Dentists and dental hygienists may also be eligible for the state dental loan repayment program.
[10] Colorado Department of Public Health and Environment, "Colorado Health Service Corps Site Requirements", 2021. https://cdphe.colorado.gov/prevention-and-wellness/health-access/colorado-health-service-corps/colorado-health-service-corps

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 not a complete analysis of this policy issue. 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.

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: IDA COSSITT-GLESNER POLICY BRIEF

SB21-018: Continuation of Necessary Document Program

Concerning continuing the necessary document program indefinitely.

Details

Bill Sponsors:	Senate – Moreno (D) House – Esgar (D)
Committee:	Senate Health & Human Services Senate Appropriations House Public & Behavioral Health & Human Services
Bill History:	2/16/2021- Introduced in Senate 2/17/2021 - Senate Health & Human Services Refer Unamended to Appropriations 4/30/2021- Senate Committee on Appropriations Refer Amended 5/4/2021- Senate Second Reading Passed with Amendments 5/5/2021- Senate Third Reading Passed 5/5/2021- Introduced in House
Next Action:	Hearing in House Public & Behavioral Health & Human Services
Fiscal Note:	February 16, 2021, for FY 2021-22, this bill requires an appropriation of $250,000 to the Department of Public Health and Environment.

Bill Summary

The bill continues the Necessary Document Program indefinitely. The program is scheduled to repeal on September 1, 2021.

The Colorado ID Project[1]

The Colorado ID Project aims to help elderly, disabled, low-income, and unhoused Coloradans or those who are victims of domestic violence or are impacted by a natural disaster and are seeking necessary documents. Necessary documents are social security cards, driver's licenses, identification cards, or a vital statistics report (i.e. birth, death, or marriage certificate). Such documentation is essential to facilitate access to housing, health care, employment, transportation, and public benefits. The ID Project provides community education and technical assistance involving identification issues; representation of individual clients needing assistance in complex cases; coordination of advocacy efforts including litigation, administrative, and legislative approaches; and management of a supplemental document fund for individuals and nonprofits to pay needed document fees. Of note, the program does not help to reinstate driving privileges or commercial driver's licenses. The Colorado ID Project is facilitated via coordination between Metro Caring, Colorado Coalition for the Homeless, the Department of Human Services at the City and County of Denver, and Colorado Legal Services.

The program is administered by the Colorado Department of Public Health and Environment (CDPHE) through the Office of Health Equity, which contracts with nonprofit organizations. The program funds approximately 10,500 documents per year.

[1] Colorado Crisis Services, "Colorado ID Project", 2021. https://coloradoidproject.wordpress.com/

Supporters

- Colorado Academy of Family Physicians
- Colorado Center on Law & Policy
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Dental Association
- Florence Crittenton Services
- Healthier Colorado
- Hunger Free Colorado
- League of Women Voters of Colorado
- Stand for Children, Inc.
- Common Cause

Opponents

- Any opposition has not been made public at this time

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 not a complete analysis of this policy issue. 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.

Health District
OF NORTHERN LARIMER COUNTY

5/7/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

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 House Appropriations
Bill History:	3/18/2021- Introduced in House 4/27/2021- House Health & Insurance Committee Refer Amended to Appropriations 5/4/2021- House Appropriations Refer Amended to Committee of the Whole 5/7/2021- House Second Reading Passed with Amendments
Next Action:	House Third Reading
Fiscal Note:	5/3/2021- Reflects the bill as amended by the House Health & Insurance Committee
Demographic Note:	4/8/2021-Reflects the introduced version of the bill, not as amended in House Health & Insurance Committee

Bill Summary

The bill creates a standardized health 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 standardized plan will be a choice for those Coloradans who acquire health insurance through either of those markets, alongside currently offered plans. The bill requires 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 6 percent each year over three years.

The Commissioner of Insurance is required to apply to the secretary of the United States Department of Health and Human Services (HHS) 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.

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

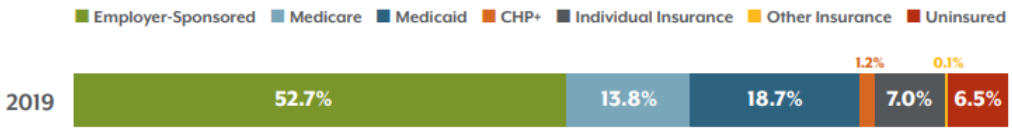
Federal Poverty Level (FPL). The legislation also codified four pillars of protections for people: guaranteed issue, adjusted community rating, prohibition against preexisting condition exclusions, and essential health benefits.[1] Under the essential health benefits, certain preventive and wellness 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
2. Emergency services
3. Hospitalization
4. Maternity & newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

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]

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[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/

[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

Health insurance plans on the individual market were nearly 50% 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 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

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[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/

[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

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%).

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

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[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

[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

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.

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. 1227[21]) 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 to protect the health, peace, safety, and general welfare of Coloradans, 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 all people have 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,

[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/do/10.1377/hblog20181023.512033/full/#:~:text=Section%201332%20allows%20states%2C%20with,the%20goals%20of%20the%20ACA.

[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

[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

particularly in the state's rural areas and for groups who have historically and systematically faced barriers to health, including people of color, immigrants, and Coloradans with low incomes. 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 and expect that the negotiated rates are closely tied to the amount of the insurance premiums paid. 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 reduction targets for carriers to achieve.

Definitions

Advisory board. The advisory board that the Commissioner consults with to implement the bill.

Critical access hospital. A hospital that is federally certified or undergoing federal certification as a critical access hospital.[24]

Essential access hospital. A critical access hospital or general hospital that is located in a rural area with 25 or fewer beds.

Essential community provider.[25] a health care provider that has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves the medically indigent patients within its medical capability; and waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

Equivalent rate. For a hospital that is a pediatric specialty hospital with a level one trauma center, the payment rate determined by the Medicaid fee schedule for the hospital from the most recent year, multiplied by a conversion factor equal to the ratio of the statewide payment to cost ratio for Medicare to the hospital's specific payment cost ratio for the most recent set of publically available hospital financial data, which is 1.52. This rate must be adjusted annually for cumulative inflation by a factor equal to the average percentage increase in the Medicare inpatient and outpatient prospective payment systems over the previous three years.

General hospital. A hospital licensed as a general hospital by CDPHE.

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.[26]

Health care provider. A health care professional who is registered, certified, or licensed under Title 12[27] or a health facility licensed under Title 25.[28]

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[24] Pursuant to 42 CFR 485, Subpart F

[25] Definition set forth in C.R.S. § 25.5-8-103(6)

[26] Definition set forth in C.R.S. § 10-16-1002(2)

[27] 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.

[28] 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

Health system. A corporation or other organization that owns, contains, or operates 3 or more hospitals.
Medical inflation. The annual percentage change in the medical care index component of the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for medical care services and medical care commodities, or its applicable successor index, based on the average change in the in the medical care index over the previous 10 years.
Medicare reimbursement rate. The facility-specific reimbursement rate for a particular health care service provided under Medicare.[29] For a hospital the is reimbursed through Medicare prospective payments system for a critical access hospital, this term means the rate based on allowable costs as reported in the Medicare costs reports and the historical cost-to-charge ratios for the specific hospital.
Public benefit corporation. The public benefit corporation that is organized and operated by Connect for Health Colorado.
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.

Establishing a 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, pediatric and other essential health benefits
- Be offered through Connect for Health Colorado and through the Public Benefit Corporation
- Be a standardized benefit design that:
    - Is created through a stakeholder engagement process, including physicians, health care industry, consumer representatives, individuals who represent health care workers or who work in health care, 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 that improves access and affordability, and
    - Is designed to improve racial health equity and decrease racial health disparities, through a variety of means, which are identified collaboratively with consumer stakeholders, including:
        - Improvement of perinatal health care
        - Provide first-dollar, pre-deductible coverage for certain high-value services, such as primary care and behavioral health
- Be actuarially sound and allow a carrier to continue to meet financial requirements set forth in state law
- Comply with the ACA, including risk adjustment requirements, and state insurance requirements
- Have a network that is culturally responsive and reflects the diversity of its enrollees, to the greatest extent possible, in regards to race, ethnicity, gender identity, and sexual orientation where the network exists. And the network is no more narrow than the most restrictive network the carrier is offering for non-standardized plans in the individual market for the plan's metal tier in that rating area.

[29] "Health Insurance for the Aged Act", Title XVIII of the federal "Social Security Act". 42 U.S.C. Sec. 1395 et seq., as amended.

Each carrier must include a description of its efforts to construct diverse, culturally responsive networks that are positioned to address health equity as a part of its network access plan. Additionally, carriers must include a majority of the essential community providers in the service area in the network. If a carrier is unable to achieve such network adequacy in regards to diversity and cultural responsiveness or is more narrow than its most restrictive network, it must file an action plan with the DOI that describes its efforts to achieve these requirements. The Commissioner must promulgate rules regarding the network adequacy requirement and the action plan. 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. The DOI is not required to comply with the state procurement code for the purposes of developing the standardized plan.

The Commissioner must contract with an independent third-party to conduct an analysis, completed by January 1, 2026, of the requirements outlined in this section on health plan enrollment, health insurance affordability, and health equity. To the extent available, the analysis must include disaggregated data by race, ethnicity, gender identity, age, and ability. If the data is not available, the analysis must note that the data is unavailable. It must also include information concerning total out-of-pocket health care spending.

Standardized Health Plan- Carrier Requirements

Starting January 1, 2023, a carrier that offers an individual plan in Colorado is required to offer the standardized plan in each county where they offer an individual plan. The plan must be offered for the entire county. Similarly, a carrier offering a small group plan is required to offer the standardized plan in each county where it currently offers a small group plan. The plan must be offered for the entire county.

In the individual and small group market beginning plan year 2023, each carrier must offer a standardized plan at a premium rate that is at least 6% less than the premium rate for plans offered by the carrier in 2021, as adjusted for medical inflation. 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 6% less than the average premium rate for plans offered in that county in 2021, as adjusted for medical inflation. For individual plans, that 2021 average premium rate is calculated based on the average premium prior to applying the reinsurance program. The average premium for small group plans is solely the average premium rate for small group plans offered in that county.

For plan year 2024, the carriers offering a standardized plans are to set a goal to reduce premiums at least 12% 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, the carriers offering a standardized plans are to set a goal to reduce premiums at least 18% in comparison to 2021. The aforementioned reduction calculations and stipulations for plan years 2023 & 2024 would be applied in plan year 2025.

For plan year 2026, and each year after, each carrier and health care coverage cooperative must limit annual premium rate increases for plans in both the individual and small group markets by a rate that is no more than medical inflation, relative to the previous year.

The premium rate reductions in plan years 2023, 2024, and 2025 must account for policy adjustments deemed necessary to prevent people with low and moderate income from experiencing net increases in premium costs.

The commissions paid to insurance producers for the sale of the standardized plan must be comparable to the average commissions paid for the sale of other plans offered on the individual and small group markets.

Rate Filing for the Standardized Plans

In required rate filings, each carrier must file rates for the standardized plans at the required premium reduction rates outlined above. If a carrier or provider anticipates being unable to meet the network adequacy standards or the premium reduction targets due to a reimbursement rate dispute for the standardized plan, either party may initiate nonbinding arbitration prior to rate filing. The rate filing deadline must still be met and may not be delayed due to the arbitration process. The Commissioner cannot be required to participate or other manage any such arbitration.

If a carrier is unable to meet the required premium rate reductions, the carrier must notify the Commissioner reasons why the carrier is unable to meet the target. For rates applicable in 2023 this must be done by May 1, 2022. For rates applicable in 2024 or any subsequent year, by March 1 other the year before the rates go into effect (i.e. March 1, 2023 for plan year 2024 rates). If after January 1, 2023, a carrier notifies the Commissioner that it is unable to offer the standardized plan at the required premium rate or if the Commissioner determines, with support from an independent actuary and based on a review of the rate and form filings finds that the plan does meet premium rate requirements or network adequacy requirements, the DOI must hold a public hearing prior to approval of the carrier's final rates. Except, if a carrier does not meet the network adequacy requirements the Commissioner shall consider a carrier to have met network adequacy requirements if the carrier files the required action plan.

The Commissioner must provide public notice and opportunity to testify at the public hearing to all affected parties, including carriers, hospitals, providers, consumer advocacy organizations, and individuals. All parties have the opportunity to present evidence regarding the carrier's ability to meet network adequacy and premium reduction targets. Evidence is limited to information that is related to the reason the carrier failed to meet the network adequacy requirements for the premium rate requirements for the standardized plan in any single county. Information submitted by a party for the purposes of a public hearing is subject to the Colorado Open Records Act (CORA). The Office of Insurance Ombudsman (established later in the bill) must participate in the hearings and represent the interest of consumers. Based on the evidence at the hearing, and other available data, the Commissioner may:

- Establish carrier reimbursement rates, if necessary, for hospital services to meet the network adequacy or premium rate requirements. In determining the reimbursement rates, the Commissioner may consult with employee membership organizations that represent health care providers' employees and with hospital-based providers and must take into account the cost of adequate wages, benefits, staffing, and training needed to provide continuous quality care.

    - The base reimbursement rate for hospital services is at least 155% of Medicare or equivalent rate
    - An essential access hospital or an independent hospital must receive a 20% increase in the base reimbursement rate
    - An essential access hospital that is not part of a health system must receive a 40% increase in the base reimbursement rate
    - A hospital that is a pediatric specialty hospital with a level one pediatric trauma center must receive a 55% increase from the base reimbursement rate and is not eligible for any additional reimbursement factors
    - A hospital with a combined percentage of Medicaid or Medicare patients that exceeds the statewide average must receive up to a 30% increase in the base reimbursement rate, with the actual increase determined based on the hospital's share of such patients
    - A hospital that is efficient in managing the underlying cost of care, as determined by total margins, operating costs, and net patient revenue, must receive up to a 40% increase in the base reimbursement rate
- Establish reimbursement rates, if necessary, for providers for categories of service within the geographic service area of the standardized plan. The rates may not be less than 135% of Medicare.
- Require hospitals and providers to accept the established reimbursement rates, if necessary to ensure the standardized plan has an adequate network and meets premium rate requirements
    - The Commissioner cannot require a provider, other than a hospital, that provides a majority of professional services through a single, contracted medical group for a nonprofit, nongovernment health maintenance organization (HMO) to contract with any other carrier
- Require the carrier to offer the standardized plan in specific counties, where no carrier is offering the standardized plan in either the individual or small group market.
    - The Commissioner must consider the carrier's structure, the number of covered lives the carrier has in all lines of business in each county, the carrier's existing service areas, as well as if there is alternative health care coverage in the county (including health care coverage cooperatives)

The Commissioner must promulgate rules to ensure that there is not an unfair competitive advantage for a carrier that intends to offer the standardized plan in a county where it has not previously offered plans or with a hospital with which the carrier has not previously had a contract.

Notwithstanding the previously outlined reimbursement rate structure, the Commissioner cannot set the reimbursement rates for a hospital less than 165% of Medicare or the equivalent rate and any hospital for any plan year at an amount that is more than 20% lower than the rate negotiated between the carrier and the hospital for the previous plan year. For a hospital with a negotiated reimbursement rate that is lower than 10% of the statewide median, measured as a percentage of Medicare for the 2021 plan year (using data from the All-Payer Claims Database [APCD]) the Commissioner must set the rate for that hospital at no less than the greater of the following:

- The hospital's commercial reimbursement rate as a percentage of Medicare minus 1/3 of the difference between the hospital's 2021 commercial reimbursement rate as a percentage of Medicare and the rate that was outlined above (155% + whatever additions it is eligible for)
- 165% of Medicare or the equivalent rate

- Or the rate that was outlined above (155% + whatever additions it is eligible for)

A carrier or provider may appeal a decision by the Commissioner to the district court in the applicable jurisdiction. The decision of the Commissioner is a final agency action subject to judicial review.

A health care coverage cooperative, and a carrier offering plans under agreement with the cooperative, that has offered one or more plans in the individual and small group markets and have previously achieved and maintained at least an 18% premium rate reduction, regardless of when it was first offered, shall be deemed by the Commissioner as meeting the requirements for carriers in this section.

The Commissioner must take into account any actuarial differences between the standardized plan and the health plans that the carrier offered in 2021, any changes to the standardized plan, and any state or federal health benefit coverage mandates implemented after the 2021 plan year.

If the 1332 waiver (discussed later in the bill), is denied, suspended, or otherwise rescinded, the DOI may adjust the premium reduction target for the individual market to maximize available subsidies.

A hospital or provider is prohibited from balance billing consumers enrolled in the standardized plan for services covered by the plan and must accept the reimbursement rates established by the Commissioner.

The Commissioner must only set reimbursement rates for hospitals or providers that prevented a carrier from meeting premium rate requirements or caused the carrier to fail to meet network adequacy requirements. The carrier must provide the Commissioner with reasonable information necessary to identify which hospitals or providers were the cause of the carrier's failure to meet either or both of those requirements. The Commissioner cannot use the failure of a carrier to meet the premium rate reductions for the standardized plan in a county as a reason to deny premium rates for a non-standardized plan in that county.

Advisory Committee

The Commissioner shall consult with an advisory committee to implement the bill. The Governor must appoint the members by July 1, 2022. The advisory committee, to the extent possible, must be diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, and gender identity. The Governor must attempt to ensure that at least 1/3 of the members are people of color and members must be from both rural and urban areas of the state. There may be up to 11 members, and to the extent practicable, be individuals who:

- Have faced barriers to health access, including people of color, immigrants, and those with low incomes
- Have experience purchasing the standardized plan
- Represent consumer advocacy groups
- Have expertise in health equity
- Have expertise in health benefits for small businesses
- Represent carriers, or have experience designing a health plan and setting rates
- Represent hospitals, or have experience with contracts between hospitals and carriers
- Represent providers, or have experience with contracts between providers and carriers
- represent an employee organization that represents employees in the health care industry or

- Are licensed or retired physicians practicing or who practiced in Colorado

Members serve at the pleasure of the Governor. The DOI must provide technical and administrative support to assist the Advisory Board.

In addition to consulting with the Commissioner, the Advisory Board may:

- Consider recommendations to streamline prior authorization and utilization management processes for the standardized plan
- Recommend ways to keep health care services in the communities where patients live
- Consider whether alternative payment models may be appropriate for particular services, taking into consideration the impacts of such models on health outcomes for people of color.

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 for the Colorado Health Insurance Affordability Enterprise to increase the value, affordability, quality, and equity of health care coverage, with a focus on these issues for Coloradans historically and systematically disadvantaged by health and economic systems. The implementation of the premium rate reduction requirements is contingent upon approval of the 1332 waiver and receiving the related federal funds.

Cost Shift

If the administrator of a self-funded plan voluntarily provides the Commissioner its contracted rates and any other necessary information, the Commissioner may evaluate whether the rates of the self-funded plan reflect a cost shift between that plan and the standardized plan. If the Commissioner determines there is a cost shift, the Commissioner shall, to the extent practicable, provide a description of which categories of services have experienced the greatest cost shift to the self-funded plan.

Third-Party Reports

The Commissioner must contract with an independent third party to prepare three separate reports, to the extent that information is available regarding the implementation of the standardized plan as it relates to staffing, wages, benefits, training, working conditions of hospital workers, and as it relates to provider workload, including any impact on the size of the provider panels, if available. In choosing a contractor, the Commissioner must consider organizations with experience conducting in-person interviews with health care employers and employees in Colorado. The contractor may make policy recommendations related to information in the reports and may include data collected from employers, employees, and other sources. These reports must be delivered to the Commissioner as follows: July 1, 2023, July 1, 2024, and July 1, 2025. This section is repealed July 1, 2026.

SMART Act Hearing Reports

The Commissioner must report during SMART Act hearings[30] the following:

1. Beginning in January 2022, and each year after, on the progress of the implementation and operation of the standardized plan

[30] Enacted 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.

2. Beginning in January 2024, and each year after, on the carriers' efforts to develop networks that are diverse and culturally responsive and other network adequacy requirements
3. In January 2024, January 2025, and January 2026 on the results of the third party reports detailed above.

Rules

The Commissioner can promulgate rules that are necessary to develop, implement, and operate the bill.

Severability

If any provision of the bill is judged invalid, it does not affect the provisions that can continue to occur without the invalid provision.

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.

Standardized Plan Survey

The bill requires Connect for Health Colorado, in collaboration with the DOI, to conduct a survey that addresses the experience of consumers who purchased the standardized health plan. The survey must be completed by January 1, 2026. This section is repealed effective July 1, 2026.

Provider Acceptance of the Standardized Health Plan

The Commissioner may require a provider, after the public hearing, to participate in the standardized plan and accept the set reimbursement rates. If the Director of Division of Professions and Occupations receives notice from the Commissioner that an applicant, licensee, certificate holder, or registrant refuses to participate in the standardized plan or accept the reimbursement rate, the Director shall issue a warning to that applicant, licensee, certificate holder, or registrant. If the individual continues to refuse after receiving the warning, the Director may impose an administrative fine not to exceed $5,000 per calendar year. The imposition of the fine does not constitute disciplinary action.

Hospital Acceptance of the Standardized Health Plan

The Commissioner may require a hospital, after the public hearing, to participate in the standardized plan and accept the set reimbursement rates. If CDPHE receives notice from the Commissioner that a hospital refuses to participate in the standardized plan or accept the reimbursement rate, the Director shall issue a warning to the hospital. If the hospital continues to refuse after receiving the warning, CDPHE shall fine the hospital up to $10,000 per day for the first 30 days or refusal and up to $40,000 per day after those first 30 days. Additionally, CDPHE may suspend, revoke, or impose conditions on the hospital's license. In determining the appropriate penalty, CDPHE must consider any penalties

recommended by the Commissioner, the hospital's financial circumstances, and other circumstances deemed relevant by the department.

Creation of Ombudsman

Within HCPF, an Ombudsman position is created to act as the advocate for consumer interests in matters related to the access and affordability of the standardized health plan. The Ombudsman shall:

- Interact with consumers regarding their access, affordability, and coverage issues with the standardized plan
- Evaluate data to assess the standardized plan's network and affordability, and
- Represent consumer interests in the DOI's public hearings regarding the rates and networks of the standardized plans

In performing these duties, the Ombudsman shall act independently of HCPF. Any recommendations or positions of the Ombudsman of not reflect those of HCPF.

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

For FY 2021-22, the bill increases state expenditures by $1.5 million and a total of 7.3 FTE in multiple state agencies. For FY 2022-23 it necessitates expenditures of $1.9 million and 8.8 FTE, which continues in future fiscal years.

Demographic Note

The demographic note, which reflects the introduced version of the bill, analyzers the potential impacts of the bill on disparities in economic and health outcomes, based on available data. The demographic note found the following. If the bill expands access to health care or lowers insurance premiums, economic and health outcomes will improve for several populations in the state, including but not limited to lower income, uninsured, and rural populations. To the extent that reduced-premium health plans result in lower reimbursement rates for health care providers, the bill will have economic impacts for affected health care providers. To the extent that these health care providers respond by reducing the provision of health care services, employment and health outcomes for those in the provider's service region may be reduced. Many of these impacts depend on how the bill is implemented and cannot be determined at this time.

Reasons to Support

Many Colorado residents continue to struggle with health insurance costs and too few options. A standardized health plan could offer consumers across the state a lower-cost plan option than would otherwise not be available. This approach gives the industry - including hospitals, insurance carriers, and drug manufacturers - the chance to work together to lower the driving costs of health care.

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, ensuring that small businesses have more affordable options and can more easily offer health benefits and retain employees.

Supporters

- Boulder County
- Centennial State Prosperity
- Center for Health Progress
- Colorado Center on Law & Policy
- Colorado Children's Campaign
- Colorado Community Health Network
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Nurses Association
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Committee to Protect Medicare
- Counties & Commissioners Acting Together (CCAT)
- Good Business Colorado
- Healthier Colorado
- Hopewell Fund
- Justice Reskill
- League of Women Voters Colorado
- Mental Health Colorado
- Small Business Majority
- United States of Care

Reasons to Oppose

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. This could make standardizing the plan product difficult and skew the affordability benchmarking.

Some assert that physicians and other health care providers will be the main levers used by other health care industries to achieve the premium cost-cutting goals. Some providers assert that quality could be affected, in part because how revenue cuts might impact the ability to recruit the best providers.

Any mandate for providers to participate may harm access to care for 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 contract with carriers providing the standardized plan, they may have to reduce the number or frequency of public insurance patients they see in order to remain financially solvent.

Some may consider an 18% reduction in three years is to extreme. There may be a possibility that carriers drop out of the small group or individual market in Colorado.

Opponents

- Adams County Regional Economic Partnership
- America's Health Insurance Plans
- Americans for Prosperity
- Anthem Blue Cross and Blue Shield
- Associated Governments of Northwest Colorado
- Centennial Institute at Colorado Christian University
- Cigna
- Colorado Ambulatory Surgery Center Association
- Colorado Association of Medical Equipment Services

- Colorado Bankers Association
- Colorado Chamber of Commerce
- Colorado Competitive Council
- Colorado Concern
- Colorado Contractors Association
- Colorado Medical Society
- Colorado Obstetrical & Gynecological Society
- Colorado Radiological Society
- Colorado Retail Council
- Colorado Society of Anesthesiologists
- Colorado Society of Eye Physicians & Surgeons
- 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
- Hispanic Contractors Colorado
- Kaiser Foundation Health Plan
- Kaiser Permanente
- Mednax
- National Federation of Independent Business
- Optum
- Pacific Dental Services
- Panorama
- Partnership for America's Health Care Future Action
- Rocky Mountain Mechanical Contractors Associations
- South Metro Denver Chamber
- United Health Care
- U.S. Anesthesia Partners of Colorado

Other Positions

Organizations with an Amend Position

- Colorado Association of Health Plans
- Colorado Chapter, College of Emergency Physicians
- Colorado Psychiatric Society
- Colorado Society of Osteopathic Medicine
- Craig Hospital
- Denver Health & Hospital Authority
- National Association of Insurance and Financial Advisors - Colorado
- Peak Health Alliance
- SCL Health
- Service Employees International Union
- UCHealth

Organizations with a Monitor or Neutral Position

- AMGEN
- American Academy of Pediatrics
- American Cancer Society, Cancer Action Network
- American Property Casualty Insurance Association
- Children's Hospital Colorado
- Colorado Academy of Family Physicians
- Colorado AFL-CIO
- Colorado Association of Family Child Care
- Colorado Association of Municipal Utilities
- Colorado Behavioral Healthcare Council
- Colorado BioScience Association
- Colorado Health Care Association
- Colorado Hospital Association
- Colorado Nonprofit Association
- Colorado Rural Health Center
- Common Sense Institute
- Davita
- Denver Water
- Friday Health Plans
- Greenwich Biosciences
- HopeWest Colorado
- Leading Age Colorado

- Novo Nordisk
- Rocky Mountain Crisis Partners
- Special District Association of Colorado

Other Considerations

Why is the implementation of the premium rate reduction requirements is contingent upon approval of the 1332 waiver and receiving the related federal funds?

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.

Health District Priority 1 Bills

Concerning the establishment of the health care services reserve corps task force.
Sponsors: K. Mullica (D) | Y. Caraveo (D) / L. Garcia (D)

The bill creates the health care services reserve corps task force (task force) in the department of public health and environment. The purpose of the task force is to evaluate and make recommendations on the creation of a health care services reserve corps program (program), in which medical professionals could cross-train to be able to serve the state in an emergency or disaster and receive student loan relief for their service. The task force is required to consider and make findings and recommendations on issues including:

- The types of medical professionals who could participate in a health care services reserve corps program, including how to ensure an appropriate cross section of providers;
- The types of emergencies and disasters for which the program could prepare and provide assistance, and whether the program could be deployed out of state;
- Any legal or regulatory obstacles to creating such a program;
- Liability protections for professionals and facilities participating in the program;
- Whether the program could be streamlined or integrated with existing programs or procedures;
- The types and hours of training that would be required;
- How to ensure the program and cross-training are accessible to rural medical professionals;
- The costs associated with the program;
- Issues related to insurance coverage and reimbursement;
- How the health care services reserve corps would be deployed; and
- The amount, terms of, and funding for the student loan relief that participants would receive.

The task force is required to consult with medical and nursing schools in making recommendations related to the cross-training elements of the program. The task force is authorized to consult with additional stakeholders with expertise in identifying the physical and mental health needs of Coloradans or in coordinating emergency response at the local, state, or federal level to identify additional questions for future consideration by the program. The task force is required to submit a report with its findings and recommendations to the house public health care and human services committee and the senate health and human services committee by December 1, 2023. The task force is required to meet at least once every 2 months. Task force members serve without compensation and are not eligible for reimbursement for expenses. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Health & Insurance
2/24/2021 House Committee on Health & Insurance Refer Amended to Appropriations
5/7/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole

Concerning expansion of the prescription drug monitoring program to track information regarding all prescription drugs prescribed in Colorado.
Sponsors: J. Rich (R) | K. Mullica (D) / B. Pettersen (D) | D. Coram (R)

Current law requires the prescription drug monitoring program (program) to track all controlled substances prescribed in Colorado. The bill expands the program, effective February 1, 2023, to track all prescription drugs prescribed in this state. The bill extends the repeal of the program until September 1, 2028. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Health & Insurance
3/24/2021 House Committee on Health & Insurance Refer Amended to Finance
4/5/2021 House Committee on Finance Refer Unamended to Appropriations
5/7/2021 House Committee on Appropriations Refer Unamended to House Committee of the Whole

Position: Support
Concerning supporting the peer support professional workforce, and, in connection therewith, making an appropriation.
Sponsors: R. Pelton (R) | Y. Caraveo (D) / R. Zenzinger (D) | D. Hisey (R)

The bill requires the department of human services (state department) to establish procedures to approve recovery support services organizations for reimbursement of peer support professional services. The bill also gives the executive director of the state department rule-making authority to establish other criteria and standards as necessary. The bill permits a recovery support services organization to charge and submit for reimbursement from the medical assistance program certain eligible peer support services provided by peer support professionals. The bill authorizes the department of health care policy and financing to reimburse recovery support services organizations for permissible claims for peer support services submitted under the medical services program. The bill requires contracts entered into between the state department's office of behavioral health and designated managed service organizations to include terms and conditions related to the support of peer-run recovery support services organizations. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/9/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to Finance
3/29/2021 House Committee on Finance Refer Amended to Appropriations
4/23/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole
4/23/2021 House Second Reading Special Order - Passed with Amendments - Committee
4/26/2021 House Third Reading Passed - No Amendments
4/27/2021 Introduced In Senate - Assigned to Finance
5/5/2021 Senate Committee on Finance Refer Unamended to Appropriations

Concerning a clarification under the Colorado open meetings law of the requirements governing communication by electronic mail that does not relate to the substance of public business.
Sponsors: J. Arndt (D) / J. Ginal (D)

Under current provisions of the Open Meetings Law (OML), if elected officials use electronic mail to discuss pending legislation or other public business among themselves, the electronic mail constitutes a meeting that is subject to the OML's requirements. The bill substitutes the word "exchange" for the word "use" in describing the type of electronic mail communication that triggers the application of the OML. The bill also clarifies existing statutory provisions to specify that electronic mail communication between elected officials that does not relate to the merits or substance of pending legislation or other public business is not a meeting for OML purposes. Under the bill, the type of electronic communication that also does not constitute a meeting for OML purposes includes electronic communication regarding scheduling and availability as well as electronic communication that is sent by an elected official for the purpose of forwarding information, responding to an inquiry from an individual who is not a member of the state or local public body, or posing a question for later

discussion by the public body. *The bill defines the term "merits or substance" to mean any discussion, debate, or exchange of ideas, either generally or specifically, related to the essence of any public policy proposition, specific proposal, or any other matter being considered by the governing entity .*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
2/22/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Unamended to House Committee of the Whole
2/25/2021 House Second Reading Laid Over to 03/01/2021 - No Amendments
3/1/2021 House Second Reading Passed with Amendments - Floor
3/2/2021 House Third Reading Passed - No Amendments
3/4/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/18/2021 Senate Committee on State, Veterans, & Military Affairs Refer Unamended to Senate Committee of the Whole
3/22/2021 Senate Second Reading Passed - No Amendments
3/23/2021 Senate Third Reading Passed - No Amendments
3/29/2021 Sent to the Governor
4/7/2021 Governor Signed

Position: Support
Concerning expanding the peace officers mental health support grant program to include community partnerships.
Sponsors: J. McCluskie (D) | H. McKean (R) / J. Buckner | J. Cooke (R)

The bill expands the peace officers mental health support grant program to include funding for on-scene response services to enhance law enforcement's handling of calls for services related to persons with mental health disorders and social service needs, including calls that do not require the presence of a peace officer. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services + Appropriations
3/5/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to Appropriations
5/7/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole

BILL
Concerning the ability of local governments to exert authority after the initial imposition of a statewide disaster emergency declaration having legal effects within their territorial boundaries.
Sponsors: S. Luck (R)

The bill permits the majority of the governing body of any county or municipality by adoption of a resolution, ordinance, law, or rule to abrogate all or any portion of a disaster emergency order applying to the county or municipality that has been issued by the governor under the governor's emergency management powers when the disaster emergency lasts longer than 30 days. Upon the enactment by the governing body of such a

resolution, ordinance, law, or rule the order, or any portion of the order, has no legal force and effect within, as applicable, the municipality or within the unincorporated portions of the county where the resolution, ordinance, law, or rule has been approved by the governing body of a county. The bill prohibits the state and any state department, institution, or agency from taking any action against a county or municipality, including without limitation any action resulting in denial of a monetary payment or the provision of any other form of financial assistance in retaliation for action by the governing body of the county or municipality to abrogate the governor's order. The bill requires the governing body of the county or municipality to notify the governor and any affected state departments, institutions, or agencies of the adoption of such resolution, ordinance, law, or rule. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/5/2021 House Committee on Public & Behavioral Health & Human Services Postpone Indefinitely

BILL _____

Concerning the control of a local government over a health order that applies within the territory of a local government.
Sponsors: A. Pico (R)

The bill specifies that a health order issued by a county, district, or municipal public health agency, public health director, or board of health takes effect within the territory of a county, city and county, or municipality, unless the governing body of the county, city and county, or municipality rejects the order by a majority vote. The bill also allows the governing body of a county, city and county, or municipality to modify a health order issued by a county, district, or municipal public health agency, public health director, or board of health. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/5/2021 House Committee on Public & Behavioral Health & Human Services Postpone Indefinitely

_____

Concerning the "Workers' Compensation Act of Colorado", and, in connection therewith, making changes that affect the timely payment of benefits, guardian ad litem and conservator services, benefit offsets related to the receipt of federal disability or retirement benefits, the reduction of benefits based on apportionment, the selection of independent medical examiners, limits on temporary disability and permanent partial disability payments, the withdrawal of admissions of liability, mileage expense reimbursement, the authority of prehearing administrative law judges, the reopening of permanent total disability awards, and petitions for review and appeals of orders.
Sponsors: M. Gray (D) | K. Van Winkle (R) / J. Bridges (D) | J. Cooke (R)

The bill:

- Adds guardian ad litem and conservator services to the list of medical aid that an employer is required to furnish to an employee who is incapacitated as a result of a work-related injury or occupational disease (**section 1** of the bill);
- Requires an injured worker who is claiming mileage reimbursement for travel related to obtaining compensable medical care to submit a request to the employer or insurer within 120 days after the expense is incurred, and requires the employer or insurer to pay or dispute mileage within 30 days after

submittal and to include in the brochure of claimants' rights an explanation of rights to mileage reimbursement and the deadline for filing a request (**sections 1 and 7**);
- Clarifies that offsets to disability benefits granted by the federal "Old-Age, Survivors, and Disability Insurance Amendments of 1965" only apply if the payments were not already being received by the employee at the time of the work-related injury (**section 2**);
- Prohibits the reduction of an employee's temporary total disability, temporary partial disability, or medical benefits based on apportionment under any circumstances; limits apportionment of permanent impairment to specific situations; and declares that the employer or insurer bears the burden of proof, by a preponderance of the evidence, at a hearing regarding apportionment of permanent impairment or permanent total disability benefits (**section 3**);
- Adds the following conditions that must be met for an employer or insurer to request the selection of an independent medical examiner when an authorized treating physician has not determined that the employee has reached maximum medical improvement (MMI): An examining physician must have examined the employee at least 20 months after the date of the injury, have determined that the employee has reached MMI, and have served a written report to the authorized treating physician specifying that the examining physician has determined that the employee has reached MMI; and the authorized treating physician must have responded that the employee has not reached MMI or must have failed to respond within 15 days after service of the report (**section 4**);
- Changes the whole person impairment rating applicable to an injured worker from 25% to 19% for purposes of determining the maximum amount of combined temporary disability and permanent partial disability payments an injured worker may receive (**section 5**);
- Clarifies when benefits and penalties payable to an injured worker are deemed paid (**section 6**);
- Prohibits an employer or insurer from withdrawing an admission of liability when 2 years or more have passed since the date the admission of liability on the issue of compensability was filed, except in cases of fraud (**section 7**);
- Prohibits the director of the division of workers' compensation or an administrative law judge from determining issues of compensability or liability unless specific benefits or penalties are awarded or denied at the same time (**section 8**);
- Clarifies the scope of authority of prehearing administrative law judges (**section 9**);
- Increases the threshold amount that an injured worker must earn in order for permanent total disability payments to cease and allows for annual adjustment of the threshold amount starting in 2022 (**section 11**); and
- Clarifies the orders that are subject to review or appeal (**sections 10 and 12**). *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Business Affairs & Labor
2/24/2021 House Committee on Business Affairs & Labor Refer Amended to Appropriations
4/23/2021 House Committee on Appropriations Refer Unamended to House Committee of the Whole
4/23/2021 House Second Reading Special Order - Passed with Amendments - Committee
4/26/2021 House Third Reading Passed - No Amendments
4/27/2021 Introduced In Senate - Assigned to Business, Labor, & Technology

BILL _____
Concerning publicly available information about applicants for public employment.
Sponsors: T. Geitner (R) | S. Bird (D) / B. Pettersen (D) | L. Liston (R)

Under the bill, a state public body conducting a search for a chief executive officer of an agency, authority, institution, or other entity is required to name one or more candidates as finalists and to make the finalist or

finalists public prior to making an offer of employment. The application materials of an applicant for any employment position, including an applicant for an executive position who is not a finalist, are not subject to public inspection under the "Colorado Open Records Act". The bill repeals a provision requiring that, if 3 or fewer candidates for an executive position meet the minimum requirements for the position, all of those candidates must be treated as finalists and their application materials are public records. *The bill requires the disclosure of demographic data concerning the race and gender of a candidate who was interviewed but not named as a finalist for a chief executive officer position, if that information was legally requested and voluntarily provided.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In House - Assigned to Business Affairs & Labor
3/25/2021 House Committee on Business Affairs & Labor Refer Amended to House Committee of the Whole
3/30/2021 House Second Reading Passed with Amendments - Committee
4/1/2021 House Third Reading Passed - No Amendments
4/6/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
4/22/2021 Senate Committee on State, Veterans, & Military Affairs Refer Unamended to Senate Committee of the Whole
4/27/2021 Senate Second Reading Passed - No Amendments
4/28/2021 Senate Third Reading Passed - No Amendments

Position: Strongly Support
Concerning a housing assistance exception to the requirement to verify lawful presence in the United States for public benefits.
Sponsors: D. Jackson (D) / J. Gonzales (D)

The bill creates, *unless otherwise required by federal law* , a public or assisted housing benefit exception to the requirement that an applicant for federal, state, or local public benefits verify lawful presence in the United States. *(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
2/25/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Amended to House Committee of the Whole
3/2/2021 House Second Reading Passed with Amendments - Committee, Floor
3/3/2021 House Third Reading Passed - No Amendments
3/5/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/23/2021 Senate State, Veterans, & Military Affairs Refer Unamended to Senate Committee of the Whole
3/26/2021 Senate Second Reading Passed - No Amendments
3/30/2021 Senate Third Reading Passed - No Amendments
4/5/2021 Sent to the Governor
4/15/2021 Governor Signed

Concerning measures to promote social distancing for legal marijuana, and, in connection therewith, modifying the physical examination procedure to obtain a medical marijuana card and repealing the prohibition on selling retail marijuana products online and to a person not physically present in the retail marijuana store's licensed premises.
Sponsors: M. Gray (D) / J. Gonzales (D)

Under current law, a physician is required to conduct an in-person physical examination of a person prior to certifying that the person would benefit from medical marijuana. The bill permits a physician to treat, counsel, and conduct appropriate personal physical examinations, in person or remotely via telephone or video conference, to establish a bona fide physician-patient relationship with a patient seeking a medical marijuana card. Under current law, retail marijuana stores are prohibited from selling retail marijuana and retail marijuana products online and to a person not physically present in the retail marijuana store's licensed premises. The bill repeals this prohibition.*(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Business Affairs & Labor + Finance

Concerning health insurance coverage for an annual mental health wellness examination performed by a qualified mental health care provider.
Sponsors: D. Michaelson Jenet (D) | B. Titone (D) / D. Moreno (D)

The bill adds a requirement, as part of mandatory health insurance coverage of preventive health care services, that health plans cover an annual mental health wellness examination of up to 60 minutes that is performed by a qualified mental health care provider. The coverage must:

- Be comparable to the coverage of a physical examination;
- Comply with the requirements of federal mental health parity laws; and
- Not require any deductibles, copayments, or coinsurance for the mental health wellness examination.

The coverage applies to plans issued on or after January 1, 2022. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Health & Insurance
5/5/2021 House Committee on Health & Insurance Refer Amended to Appropriations

Concerning civil immunity for entities that comply with applicable health guidelines related to COVID-19.
Sponsors: M. Bradfield

The bill establishes immunity from civil liability for entities for any act or omission that results in exposure, loss, damage, injury, or death arising out of COVID-19 if the entity attempts in good faith to comply with applicable public health guidelines. The bill is repealed 2 years after the date the governor terminates the state of disaster emergency declared on March 11, 2020. *(Note: This summary applies to this bill as introduced.)*
Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs

3/11/2021 House Committee on State, Civic, Military, & Veterans Affairs Postpone Indefinitely

Position: Strongly Support
Concerning replacing the term "illegal alien" with "worker without authorization" as it relates to public contracts for services.
Sponsors: S. Lontine (D) / J. Gonzales (D)

The bill replaces the term "illegal alien" with "worker without authorization" as it relates to public contracts for services. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
2/25/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Unamended to House Committee of the Whole
3/2/2021 House Second Reading Passed - No Amendments
3/3/2021 House Third Reading Passed - No Amendments
3/4/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/23/2021 Senate Committee on State, Veterans, & Military Affairs Refer Unamended to Senate Committee of the Whole
3/26/2021 Senate Second Reading Passed - No Amendments
3/30/2021 Senate Third Reading Passed - No Amendments
4/5/2021 Sent to the Governor
4/15/2021 Governor Signed

Concerning the duration of a state of disaster emergency declared by the governor, and, in connection therewith, prohibiting the governor from renewing a state of disaster emergency and authorizing the general assembly to extend a state of disaster emergency.
Sponsors: A. Pico (R)

The bill extends the duration of a state of disaster emergency declared by the governor from 30 to 60 days, but prohibits the governor from renewing a state of disaster emergency declared beyond 60 days. Instead, the bill authorizes the general assembly, upon the written request of the governor and by adopting a joint resolution, to extend the state of disaster emergency for up to 60 additional days. The general assembly may continue, at the written request of the governor and by adopting a joint resolution for each extension, to extend a state of disaster emergency for periods of up to 60 days for as long as it deems it necessary to do so. If the general assembly is not scheduled to convene in a regular session when a state of disaster emergency will end as required by the bill, the governor or a two-thirds majority of the members of each house of the general assembly, in accordance with applicable state constitutional provisions, may call the general assembly into an extraordinary session to consider extending the state of disaster emergency. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
3/18/2021 House Committee on State, Civic, Military, & Veterans Affairs Postpone Indefinitely

Concerning secure transportation for an individual in behavioral health crisis.
Sponsors: J. McCluskie (D) | C. Larson (R) / J. Bridges (D) | J. Smallwood (R)

The bill creates a regulatory and service system to provide secure transportation services, with different requirements from traditional ambulance services, for individuals experiencing a behavioral health crisis. The department of human services shall allow for the development of secure transportation alternatives. The board of county commissioners of the county in which the secure transportation service is based (commissioners) shall issue a license to an entity (licensee), valid for 3 years, that provides secure transportation services if the minimum requirements set by rule by the state board of health are met or exceeded. The commissioners shall also issue operating permits, valid for 12 months following issuance, to each vehicle operated by the licensee. A fee may be charged for each license to reflect the direct and indirect costs to the applicable county in implementing secure transportation services licensure. The state board of health is given authority to promulgate rules concerning secure transportation licensure. The department of health care policy and financing (department) is directed to create and implement a secure transportation benefit on or before January 1, 2023. The department is required to include information on secure transportation services and benefits in its annual "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" report. The bill exempts secure transportation services from regulation under the public utilities commission. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/23/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to Appropriations
5/7/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole

Concerning recommendations from the Colorado behavioral health task force, and, in connection therewith, establishing a behavioral health administration.
Sponsors: M. Young (D) | R. Pelton (R) / R. Fields (D) | B. Gardner (R)

The bill addresses multiple recommendations from the Colorado behavioral health task force (task force), created in 2019, related to the creation of a behavioral health administration (BHA). The BHA would be a single state agency to lead, promote, and administer the state's behavioral health priorities. The bill requires the department of human services (department) to submit a plan for the creation and establishment of the BHA on or before November 1, 2021, to the joint budget committee and on or before January 30, 2022, to the department's committees of reference. The bill outlines what the plan must, at a minimum, include. The essential duties of the BHA, once established, are set forth. A timeline is described for the establishment of the BHA in the department and for a future determination of what state department, if different than the department of human services, the BHA will exist. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/9/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to House Committee of the Whole
3/12/2021 House Second Reading Passed with Amendments - Committee
3/16/2021 House Third Reading Passed - No Amendments
3/18/2021 Introduced In Senate - Assigned to Health & Human Services

4/5/2021 Senate Committee on Health & Human Services Refer Unamended to Senate Committee of the Whole
4/8/2021 Senate Second Reading Passed - No Amendments
4/9/2021 Senate Third Reading Passed - No Amendments
4/14/2021 Sent to the Governor
4/22/2021 Governor Signed

Concerning measures to secure firearms to prevent use by persons not lawfully permitted to possess firearms.
Sponsors: M. Duran (D) | K. Mullica (D) / J. Bridges (D) | C. Hansen (D)

The bill requires that firearms be responsibly and securely stored when they are not in use to prevent access by unsupervised juveniles and other unauthorized users. The bill creates the offense of unlawful storage of a firearm if a person stores a firearm in a manner that the person knows, or should know:

- That a juvenile can gain access to the firearm without the permission of the juvenile's parent or guardian; or
- A resident of the premises is ineligible to possess a firearm under state or federal law.

Unlawful storage of a firearm is a class 2 misdemeanor. The bill requires licensed gun dealers to provide with each firearm, at the time of a firearm sale or transfer, a locking device capable of securing the firearm. Transferring a firearm without a locking device is an unclassified misdemeanor punishable by a maximum $500 fine. The bill requires the state court administrator to annually report to the general assembly about the number of charges related to unsafe firearms storage and the disposition of those charges. The bill requires the office of suicide prevention within the department of public health and environment (department) to include on its website, and in materials provided to firearms-related businesses and health care providers, information about the offense of unlawful storage of a firearm, penalties for providing a handgun to a juvenile or allowing a juvenile to possess a firearm, and the requirement that gun dealers provide a locking device with each firearm transferred. Subject to available money, the department is required to develop and implement a firearms safe storage education campaign to educate the public about the safe storage of firearms, ~~and~~ state requirements related to firearms safety and storage, *and information about voluntary temporary firearms storage programs* .

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
3/1/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Unamended to House Committee of the Whole
3/8/2021 House Second Reading Special Order - Passed with Amendments - Floor
3/9/2021 House Third Reading Passed - No Amendments
3/10/2021 Introduced In Senate - Assigned to Judiciary
4/1/2021 Senate Committee on Judiciary Refer Unamended to Senate Committee of the Whole
4/9/2021 Senate Second Reading Passed - No Amendments
4/12/2021 Senate Third Reading Passed - No Amendments
4/14/2021 Sent to the Governor
4/19/2021 Governor Signed

Position: Support
Concerning protections for certain public health workers.
Sponsors: Y. Caraveo (D) | T. Carver (R) / J. Bridges (D) | P. Lundeen (R)

Under current law, it is unlawful for a person to make available on the internet personal information of a law enforcement official (official) or a human services worker (worker), or the official's or worker's family, if the dissemination of the personal information poses an imminent and serious threat to the official's or worker's safety or the safety of the official's or worker's family. A violation of this law is a class 1 misdemeanor. Further, a worker meeting certain requirements specified in statute may submit a written request to a state or local government official to remove personal information from public records that are available on the internet. The bill adds the same protections for public health workers, including employees, contractors, or employees of contractors of the department of public health and environment, or of county or district public health agencies, who are engaged in public health duties, and for members of county or district boards of health, other than elected county commissioners. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/16/2021 Introduced In House - Assigned to Judiciary
3/2/2021 House Committee on Judiciary Refer Amended to House Committee of the Whole
3/8/2021 House Second Reading Special Order - Passed with Amendments - Committee
3/9/2021 House Third Reading Passed - No Amendments
3/10/2021 Introduced In Senate - Assigned to Judiciary
4/14/2021 Senate Committee on Judiciary Refer Unamended - Consent Calendar to Senate Committee of the Whole
4/19/2021 Senate Second Reading Passed - No Amendments
4/20/2021 Senate Third Reading Passed - No Amendments

Concerning updates to prohibitions against gender-based discrimination to clarify the individuals who are included in a protected class.
Sponsors: D. Esgar (D) / D. Moreno (D)

The bill amends the definition of "sexual orientation" and adds definitions of the terms "gender expression" and "gender identity". The bill also adds the terms "gender expression" and "gender identity" to statutes prohibiting discrimination against members of a protected class, including statutes prohibiting discriminatory practices in the following areas:

- Membership of the Colorado civil rights commission;
- Employment practices;
- Housing practices;
- Places of public accommodation;
- Publications that advertise places of public accommodation;
- Consumer credit transactions;
- Selection of patients by direct primary health care providers;
- Sales of cemetery plots;
- Membership in labor organizations;
- Colorado labor for public works projects;
- Issuance or renewal of automobile insurance policies;

- The provision of funeral services and crematory services;
- Eligibility for jury service;
- Issuance of licenses to practice law;
- The juvenile diversion program;
- Access to services for youth in foster care;
- Enrollment in a charter school, institute charter school, public school, or pilot school;
- Local school boards' written policies regarding employment, promotion, and dismissal;
- The assignment or transfer of a public school teacher;
- Leasing portions of the grounds of or improvements on the grounds of the Colorado state university - Pueblo and the Colorado school of mines;
- Enrollment or classification of students at private occupational schools;
- Training provided to peace officers concerning the prohibition against profiling;
- Criminal justice data collection;
- Employment in the state personnel system;
- The availability of services for the prevention and treatment of sexually transmitted infections;
- Membership of the health equity commission;
- The availability of family planning services;
- Requirements for managed care programs participating in the state medicaid program and the children's basic health plan;
- The treatment of and access to services by individuals in facilities providing substance use disorder treatment programs;
- Employment practices of county departments of human or social services involving the selection, retention, and promotion of employees;
- Practices of the Colorado housing and finance authority in making or committing to make a housing facility loan;
- The imposition of occupancy requirements on charitable property for which the owner is claiming an exemption from property taxes based on the charitable use of the property;
- The determination of whether expenses paid at or to a club that has a policy to restrict membership are tax deductible; and
- Practices of transportation network companies in providing services to the public.
  (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In House - Assigned to Judiciary
3/24/2021 House Committee on Judiciary Refer Amended to House Committee of the Whole
3/31/2021 House Second Reading Special Order - Passed with Amendments - Committee
4/1/2021 House Third Reading Passed - No Amendments
4/6/2021 Introduced In Senate - Assigned to Judiciary
4/21/2021 Senate Committee on Judiciary Refer Unamended to Senate Committee of the Whole
4/26/2021 Senate Second Reading Passed - No Amendments
4/27/2021 Senate Third Reading Passed - No Amendments

Concerning adding language to relevant Colorado statutes related to persons with disabilities to strengthen protections against discrimination on the basis of disability.
Sponsors: D. Ortiz (D)

The bill adds language to strengthen current Colorado law related to protections against discrimination on the basis of disability for persons with disabilities. The added provisions include:

- Prohibiting a person with a disability from being excluded from participating in or being denied the benefits of services, programs, or activities of a public entity;
- Clarifying that such prohibition includes the failure of a public entity to substantially comply with web content accessibility guidelines established and published by an international consortium;
- Any Colorado agency with the authority to promulgate rules shall not promulgate a rule that provides less protection than that provided by the "Americans with Disabilities Act of 1990". *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In House - Assigned to Judiciary
3/24/2021 House Committee on Judiciary Refer Amended to Appropriations
5/7/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole

Concerning the regulation of members of boards of health, and, in connection therewith, regulating the members of state, county, and district boards of health.
Sponsors: C. Kipp (D) | K. Mullica (D) / J. Ginal (D) | K. Priola (R)

The bill ~~specifies that members of a county or district board of health are not allowed to serve concurrently as members of a board of county commissioners and as members of a county or district board of health. The bill also allows members of a county or district board of health to be removed for malfeasance or other specified reasons~~ *requires members of a county or district board of health to attend annual public health training provided by the department of public health and environment and developed by the department of public health and environment along with the Colorado school of public health.The bill also requires the department of public health and environment to develop guidance on recruiting people to serve on county and district boards of health and to provide this guidance to any board of county commissioners, county board of health, or district board of health that requests it.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In House - Assigned to Transportation & Local Government
3/23/2021 House Committee on Transportation & Local Government Refer Amended to House Committee of the Whole
3/26/2021 House Second Reading Passed with Amendments - Committee
3/29/2021 House Third Reading Passed - No Amendments
3/30/2021 Introduced In Senate - Assigned to Local Government
4/13/2021 Senate Committee on Local Government Refer Unamended to Senate Committee of the Whole
4/16/2021 Senate Second Reading Passed with Amendments - Floor
4/19/2021 Senate Third Reading Passed - No Amendments
4/26/2021 House Considered Senate Amendments - Result was to Not Concur - Request Conference Committee
5/6/2021 Senate Consideration of First Conference Committee Report result was to Adopt Committee Report – Repass

Concerning lowering the suicide rate by enhancing care for persons affected by suicide, and, in connection therewith, broadening Colorado's focus to include suicide prevention, intervention, and postvention.
Sponsors: J. Rich (R) | L. Daugherty / K. Donovan (D) | D. Coram (R)

The bill broadens the state's priorities and focus on suicide and suicide attempts and the after-effects of those actions on attempt survivors, family, friends, health care providers, first and last responders, educators, and students in schools where a suicide or suicide attempt has occurred. ~~The following entities are renamed as follows to reflect the new state focus:~~

- ~~The "office of suicide prevention" is renamed as the "office of suicide prevention, intervention, and postvention";~~
- ~~The "suicide prevention commission" is renamed as the "suicide prevention, intervention, and postvention commission" and its duties expanded to include training and education for health care providers, first and last responders, and educators, as well as developing a plan for follow-up care for suicide attempt survivors who were treated in an emergency department;~~
- ~~The "Colorado suicide prevention plan" is renamed as the "Colorado suicide prevention, intervention, and postvention plan". The components of the plan are expanded to include training and education for health care providers, first and last responders, and educators, as well as developing a plan for follow-up care for suicide attempt survivors who were treated in an emergency department.~~
- ~~The "crisis and suicide prevention training grant program" is renamed as the "crisis and suicide prevention, intervention, and postvention training grant program"; and~~
- ~~The "suicide prevention coordination cash fund" is renamed as the "suicide prevention, intervention, and postvention coordination cash fund".~~

(Note: Italicized words indicate new material added to the original summary; ~~dashes through words~~ indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/18/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/23/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to House Committee of the Whole
3/29/2021 House Second Reading Passed with Amendments - Committee, Floor
3/30/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/31/2021 House Third Reading Passed - No Amendments
4/6/2021 Senate Committee on State, Veterans, & Military Affairs Refer Unamended - Consent Calendar to Senate Committee of the Whole
4/9/2021 Senate Second Reading Passed - No Amendments
4/12/2021 Senate Third Reading Passed - No Amendments
4/21/2021 Sent to the Governor
4/22/2021 Governor Signed

Concerning expanding the community transition specialist program.
Sponsors: D. Michaelson Jenet (D) | M. Bradfield / C. Kolker | B. Gardner (R)

The bill expands the community transition specialist program (program) by redefining "high-risk individual" to allow more individuals to access program services. The bill also expands facilities that can access program services. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/23/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/9/2021 House Committee on Public & Behavioral Health & Human Services Refer Unamended to House Committee of the Whole
3/12/2021 House Second Reading Passed - No Amendments
3/16/2021 House Third Reading Passed - No Amendments
3/19/2021 Introduced In Senate - Assigned to Health & Human Services
3/31/2021 Senate Committee on Health & Human Services Refer Unamended - Consent Calendar to Senate Committee of the Whole
4/6/2021 Senate Second Reading Passed - No Amendments
4/7/2021 Senate Third Reading Passed - No Amendments
4/14/2021 Sent to the Governor
4/20/2021 Governor Signed

Concerning protections for consumers who participate in health-care cost-sharing arrangements.
Sponsors: S. Lontine (D) / R. Fields (D)

The bill defines a "health-care cost-sharing arrangement" as a health care sharing ministry or medical cost-sharing community that collects money from its members on a regular basis, at levels established by the arrangement, for purposes of sharing, covering, or defraying the medical costs of its members. A health-care cost-sharing arrangement is required to:

- Report specified information to the commissioner of insurance (commissioner) regarding its operations, financial statements, membership, and medical bills submitted, paid, and denied in Colorado;
- Provide certain written disclosures to potential and renewing members, post the disclosures on its website, if the arrangement has a website, and include the disclosures in its marketing materials;
- Provide specified written statements about arrangement finances and guidelines about arrangement procedures to members; and
- Respond to requests for payment of medical expenses from members or health-care providers within a period specified by the commissioner by rule.

An insurance broker that offers a health-care cost-sharing arrangement in this state is required to provide written or electronic disclosures about the product to prospective members before selling the arrangement to the person. The commissioner is authorized to:

- Adopt rules to implement the data reporting, disclosure, and response time requirements;
- Impose fines for failure to comply with the requirements and prohibitions specified in the bill;
- Issue an emergency, ex parte cease-and-desist order against a person the commissioner believes to be violating the bill if it appears to the commissioner that the alleged conduct is fraudulent, creates an immediate danger to public safety, or is causing or is reasonably expected to cause significant, imminent, and irreparable public injury; and
- Impose a civil penalty, order restitution, or both, against a person that violates an ex parte cease-and-desist order.

A person is prohibited from making, issuing, circulating, or causing to be made, issued, or circulated any statement or publication that misrepresents the medical cost-sharing benefits, advantages, conditions, or terms of any health-care cost-sharing arrangement. *(Note: This summary applies to this bill as introduced.)*

Status
3/1/2021 Introduced In House - Assigned to Health & Insurance
3/23/2021 House Committee on Health & Insurance Postpone Indefinitely

The Board voted to Support HB21-1150. However, the Board encourages legislators to add language to ensure that the use of the word "integration" in the bill cannot be used in the future in any way that would support the loss of someone's cultural heritage.
Position: Support
Concerning the creation of the Colorado office of new Americans.
Sponsors: I. Jodeh (D)/ J. Gonzales (D)

The bill creates, initially within the department of labor and employment, the Colorado office of new Americans (ONA). The bill sets forth the ONA's duties and responsibilities and provides details regarding funding. The ONA serves as the point of contact for immigrant-serving state agencies, private sector organizations, and the public about immigrant issues in Colorado, and has as one of its central purposes the successful integration and inclusion of immigrants and refugees in our state's communities. 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. *(Note: This summary applies to this bill as introduced.)*

Status
3/3/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs
4/8/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Amended to Finance
4/15/2021 House Committee on Finance Refer Amended to Appropriations
5/4/2021 House Committee on Appropriations Refer Unamended to House Committee of the Whole

Concerning the prohibition against discrimination based on the refusal to obtain a COVID-19 vaccine.
Sponsors: K. Ransom (R) | T. Van Beber (R)

The bill prohibits an employer, including a licensed health facility, from taking adverse action against an employee or an applicant for employment based on the employee's or applicant's COVID-19 immunization status. The bill allows an aggrieved employee or applicant for employment to file a civil action for injunctive, affirmative, and equitable relief and, if the employer or health facility acted with malice or wanton or willful misconduct or has repeatedly violated the law, the court may also award punitive damages and attorney fees and costs. Additionally, the bill specifies that the COVID-19 vaccine is not mandatory, that the state cannot require any individual to obtain a COVID-19 vaccine, and that government agencies and private businesses, including health insurers, cannot discriminate against clients, patrons, or customers based on their COVID-19 vaccination status. A person aggrieved by a violation of these prohibitions may file a civil action for injunctive and other appropriate relief and may be awarded punitive damages and attorney fees and costs for wanton, willful, or repeated violations. *(Note: This summary applies to this bill as introduced.)*

Status
3/4/2021 Introduced In House - Assigned to Health & Insurance

April 13th: The Board voted to Support HB21-1198 if the following four amendments are made: 1) Limit the application of the bill to hospitals and freestanding emergency departments; 2) Add language for what rate to use when Medicare does not have a rate to use for reference (for example, pregnancy); 3) Incorporate provider protections in the case of patients who deliberately misrepresent their income; and 4) Remove the requirement of providing a payment plan that does not exceed 5% of monthly income for patients who are non-qualifying. Additionally, the Board suggests that legislators consider creating an option whereby, prior to the post-36 month cancellation of debt, the provider?s credit agency would be allowed to investigate assets; and if they are above a designated level, could move to collections rather than cancellation of debt.

April 27th: The Board voted to Support the bill

Position: Support

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.

Sponsors: I. Jodeh (D) / J. Buckner (D) | C. Kolker (D)

No later than June 1, 2022, a health-care facility shall screen each uninsured patient for eligibility for public health insurance programs, discounted care through the Colorado indigent care program (CICP), and discounted care as described in the bill. Health-care facilities shall use a single uniform application developed by the department of health care policy and financing (department) when screening a patient. If a health-care facility determines a patient is ineligible for discounted care, the facility shall provide the patient notice of the determination and an opportunity for the patient to appeal the determination. For emergency and other non-CICP health-care services provided to qualified patients, a health-care facility and licensed health-care professional shall limit the amounts charged to not more than 80% of the medicare rate if the patient is uninsured; collect amounts charged in monthly installments such that a patient is not paying more than 5% of the patient's household income; and after a cumulative 36 months of payments, consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid. A health-care facility shall make information about patient's rights and the uniform application for discounted care available to the public and to each patient. Beginning June 1, 2023, and each June 1 thereafter, each health-care facility shall collect and report to the department data that the department determines is necessary to evaluate compliance across patient groups based on race, ethnicity, and primary language spoken with the required screening, discounted care, payment plan, and collections practices. No later than April 1, 2022, the department shall develop a written explanation of a patient's rights, make the explanation available to the public and each patient, and establish a process for patients to submit a complaint relating to noncompliance with the requirements. The department shall periodically review health-care facilities and licensed health-care professionals (hospital providers) to ensure compliance, and the department shall notify the hospital provider if the hospital provider is not in compliance that the hospital provider has 90 days to file a corrective action plan with the department. A hospital provider may request up to 120 days to submit a corrective action plan. The department may require a hospital provider that is not in compliance to develop and operate under a corrective action plan until the department determines the hospital provider is in compliance. The bill implements fines for hospital providers if the department determines the hospital provider's noncompliance is knowing or willful. The bill imposes requirements on hospital providers before assigning or selling patient debt to a medical creditor or before pursuing any permissible extraordinary collection action and imposes fines for any hospital provider that fails to comply with the requirements. The bill prohibits a medical creditor from using impermissible extraordinary collection action to collect debts owed for health-care services provided by a hospital provider. A medical creditor may engage in permissible extraordinary collection actions 180 days after the first bill for a medical debt is sent to the patient. At least 30 days before taking any permissible extraordinary collection action, a medical creditor shall provide the patient with a notice about the discounted

care policy, the permissible extraordinary collection actions that will be initiated, and a deadline after which such permissible extraordinary collection actions will be initiated. If a patient is later found eligible for discounted care, the medical creditor shall reverse any permissible extraordinary collection actions. *(Note: This summary applies to this bill as introduced.)*

Status
3/4/2021 Introduced In House - Assigned to Health & Insurance
4/21/2021 House Committee on Health & Insurance Refer Amended to Appropriations

Concerning the ability of certain health-care providers to repurpose therapeutic drugs that have been approved by the food and drug administration for another purpose to provide treatment to individuals with COVID-19.
Sponsors: S. Luck (R)

The bill specifies that:

- A physician, physician assistant, or advanced practice registered nurse with prescriptive authority may prescribe and dispense, and a pharmacist may dispense, therapeutic drugs for off-label use, including hydroxychloroquine sulfate and ivermectin, to provide prophylaxis or outpatient (at-home) and inpatient (hospital) treatment to an individual with COVID-19; and
- This practice is not unprofessional conduct or otherwise grounds for discipline. *(Note: This summary applies to this bill as introduced.)*

Status
3/4/2021 Introduced In House - Assigned to Health & Insurance
3/31/2021 House Committee on Health & Insurance Postpone Indefinitely

Concerning the protection of critical services through the creation of sustainable medicaid transportation safety requirements, and, in connection therewith, making and reducing an appropriation.
Sponsors: C. Larson (R) | A. Valdez (D) / D. Moreno (D) | D. Coram (R)

Current law requires the public utilities commission (commission) to oversee the safety and oversight of medicaid nonmedical and nonemergency medical transportation services (transportation services). The bill eliminates the commission's responsibility to oversee the safety and oversight of the transportation services. The bill requires the department of health care policy and financing (department) to oversee the safety and oversight of the transportation services. *If a provider of transportation services already complies with the transportation safety standards established by another state department which meet or exceed the rules and processes established by the department, the provider can demonstrate compliance to the department in order to verify compliance with the requirements of the bill.* The bill also requires the department to collaborate with stakeholders*, including but not limited to disability and member advocates, transportation brokers, and transportation providers,* to establish rules and processes for the *safety and oversight of* transportation services.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.)(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)
Status
3/4/2021 Introduced In House - Assigned to Health & Insurance
4/6/2021 House Committee on Health & Insurance Refer Amended to Appropriations

4/23/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole
4/23/2021 House Second Reading Special Order - Passed with Amendments - Committee, Floor
4/26/2021 House Third Reading Passed - No Amendments
4/27/2021 Introduced In Senate - Assigned to Health & Human Services

The Board voted to remain Neutral on HB21-1232, but continue to monitor the bill as it is amended.
Position: Neutral
Concerning the establishment of a standardized health benefit plan to be offered in Colorado, and, in connection therewith, making an appropriation.
Sponsors: D. Roberts (D) | I. Jodeh (D)/ K. Donovan (D)

The bill requires the commissioner of insurance (commissioner) in the department of regulatory agencies to establish a standardized health benefit plan (standardized plan) by rule to be offered by health insurance carriers (carriers) in the individual and small group markets. The standardized plan must:

- Offer health-care coverage at the bronze, silver, and gold levels;
- Be offered through the Colorado health benefit exchange;
- Be a standardized benefit design created through a stakeholder engagement process;
- Provide first-dollar, predictable coverage for certain high value services; and
- Comply with state and federal law.

Beginning January 1, 2023, and each year thereafter, the bill encourages carriers that offer:

- An individual health benefit plan in Colorado to offer the standardized plan in the individual market; and
- A small group health benefit plan in Colorado to offer the standardized plan in the small group market.

For 2023, each carrier shall set a goal of offering a standardized plan premium that is at least 10% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2024, each carrier shall set a goal of offering a standardized plan premium that is at least 20% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2025 and each year thereafter, carriers are encouraged to limit annual premium rate increases for the standardized plan to no more than the consumer price index plus one percent, relative to the previous year. The Colorado option authority (authority) is created for the purpose of operating as a carrier to offer the standardized plan as the Colorado option if the carriers do not meet the established premium rate goals. The authority shall operate as a nonprofit, unincorporated public entity. The authority is required to implement a provider fee schedule as established by the commissioner in consultation with the executive director of the department of health care policy and financing. Health-care providers and health facilities are required to accept consumers who are enrolled in any health benefit plan offered by the authority. The bill creates an advisory committee to make recommendations to the authority concerning the development, implementation, and operation of the authority. The commissioner 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. The commissioner is required to disapprove of a rate filing submitted by a carrier if the rate filing reflects a cost shift between the standardized plan and the health benefit plan for which rate approval is being sought. The bill makes the failure to accept consumers who are covered through the Colorado option or the balance billing of a patient in violation of this bill grounds for discipline under specified practice acts. The bill repeals the authority and its functions if the United States congress establishes a national public option program that meets or

exceeds the premium rate goals set forth in and health-care coverage pursuant to this bill.
(Note: This summary applies to this bill as introduced.)

Status
3/18/2021 Introduced In House - Assigned to Health & Insurance
4/27/2021 House Committee on Health & Insurance Refer Amended to Appropriations
5/4/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole
5/7/2021 House Second Reading Passed with Amendments - Committee, Floor

Concerning establishing a temporary program to facilitate youth mental health services in response to identified needs, and, in connection therewith, making an appropriation.
Sponsors: D. Michaelson Jenet (D) | K. Van Winkle (R) / J. Buckner (D) | R. Woodward (R)

The bill establishes a temporary youth mental health services program (program) in the office of behavioral health (office) within the department of human services to facilitate access to mental health services , *including substance use disorder services*, for youth to respond to identified mental health needs, including those needs that may have resulted from the COVID-19 pandemic. The program reimburses providers for up to 3 mental health sessions with a youth and may provide additional reimbursement subject to available money. As soon as practicable, but no later than ~~May 31, 2021,~~ *July 1, 2021*, the department of human services is required to enter into an agreement with a vendor to create, or use an existing, website or web-based application as a portal available to youth and providers to facilitate the program. The program is repealed, effective June 30, 2022. The bill makes an appropriation.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
4/6/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
4/20/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to Appropriations
4/28/2021 House Committee on Appropriations Refer Unamended to House Committee of the Whole
4/28/2021 House Second Reading Passed with Amendments - Committee, Floor
4/29/2021 House Third Reading Passed - No Amendments
4/30/2021 Introduced In Senate - Assigned to Health & Human Services

Position: Support
Concerning the creation of a reproductive health care program, and, in connection therewith, providing contraceptive methods and counseling services to participants.
Sponsors: S. Jaquez Lewis (D) / Y. Caraveo (D)

The bill creates the reproductive health care program that provides contraceptive methods and counseling services to participants. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services

3/22/2021 Senate Committee on Health & Human Services Refer Unamended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

The Board recommends an amendment that would have pharmacists provide information to every patient receiving an opioid prescription that explains the issue and offers an opiate antagonist (thereby eliminating the need for the pharmacist to use their judgment or seek more information). Further, the Board recommends that a pharmacist not have liability for not directly offering an antagonist.
Position: Support
Concerning responsibilities of a pharmacist related to opiate antagonists.
Sponsors: R. Fields (D) / K. Mullica (D) | R. Pelton (R)

~~The bill authorizes a pharmacist to prescribe an opiate antagonist.~~ The bill requires a pharmacist who dispenses an opioid to an individual to inform the individual of the potential dangers of a high dose of opioid and offer to prescribe the individual an opiate antagonist if:

- ~~In the pharmacist's professional judgment, the individual would benefit from the information;~~
- ~~The individual has a history of prior opioid overdose or substance use disorder;~~
- The individual is, at the same time, prescribed a benzodiazepine, a sedative hypnotic drug, carisoprodol, tramadol, or gabapentin; or
- The opioid prescription being dispensed is at or in excess of 90 morphine milligram equivalent.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/10/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/23/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
4/27/2021 Senate Second Reading Passed with Amendments - Committee, Floor
4/28/2021 Senate Third Reading Passed - No Amendments
4/30/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

Concerning changes to allocation formulas for the Colorado child care assistance program.
Sponsors: B. Kirkmeyer (R)

The bill allows the state department of human services (state department), along with the child care allocation workgroup, to consider a utilization factor. This utilization factor would enable the state department to consider the volume of the eligible population and the service delivery cost to each county department of human or social services (county department) when allocating and distributing money for the Colorado child care assistance program (CCCAP). The bill further allows a county department to set its own eligibility levels for CCCAP, expressed as a percentage of the federal poverty level.*(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/24/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/23/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

The Board encourages only incorporation of screenings and services that are recommended by Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration (HRSA), the National Academy of Medicine (NAM), and the U.S. Preventive Services Task Force (USPSTF).

Position: Support

Concerning services related to preventive health care, and, in connection therewith, requiring coverage for certain preventive measures, screenings, and treatments that are administered, dispensed, or prescribed by health care providers and facilities and making an appropriation.

Sponsors: B. Pettersen (D) | D. Moreno (D) / D. Esgar (D) | K. Mullica (D)

The bill codifies a number of preventive health care services currently required to be covered by health insurance carriers pursuant to the federal "Patient Protection and Affordable Care Act" and adds them to the current list of services required to be covered by Colorado health insurance carriers, which services are not subject to policy deductibles, copayments, or coinsurance. The bill expands certain preventive health care services to include osteoporosis screening; urinary incontinence screening; and counseling, prevention, screening, and treatment of a sexually transmitted infection (STI). Current law requires a health care provider or facility to perform a diagnostic exam for an STI and subsequently treat the STI at the request of a minor patient. The bill allows a health care provider to administer, dispense, or prescribe preventive measures or medications where applicable. The consent of a parent is not a prerequisite for a minor to receive preventive care, but a health care provider shall counsel the minor on the importance of bringing the minor's parent or legal guardian into the minor's confidence regarding the services. Current law requires the executive director of the department of health care policy and financing to authorize reimbursement for medical or diagnostic services provided by a certified family planning clinic. The bill removes the requirement that services be provided by a certified family planning clinic and authorizes reimbursement for family planning services and family-planning-related services provided by any licensed health care provider. *(Note: This summary applies to this bill as introduced.)*

Status

2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/24/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
5/4/2021 Senate Second Reading Passed with Amendments - Committee, Floor
5/5/2021 Senate Third Reading Passed - No Amendments
5/5/2021 Introduced In House - Assigned to Health & Insurance

Concerning continuing the necessary document program indefinitely, and, in connection therewith, making an appropriation.

Sponsors: D. Moreno (D) / D. Esgar (D)

The bill continues the necessary document program indefinitely. *(Note: This summary applies to this bill as introduced.)*

Status

2/16/2021 Introduced In Senate - Assigned to Health & Human Services
2/17/2021 Senate Committee on Health & Human Services Refer Unamended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole
5/4/2021 Senate Second Reading Passed with Amendments - Committee, Floor

5/5/2021 Senate Third Reading Passed - No Amendments
5/5/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

Concerning the enactment of the "Audiology and Speech-language Pathology Interstate Compact", and, in connection therewith, making an appropriation.
Sponsors: J. Buckner (D) | D. Hisey (R) / M. Young (D) | T. Carver (R)

The bill enacts the "Audiology and Speech-language Pathology Interstate Compact" allowing audiologists and speech-language pathologists licensed in any compact state to provide:

- Audiology or speech-language pathology services in each member state under a privilege to practice; and
- Telehealth services in each member state under a privilege to practice.

The bill authorizes the director of the division of professions and occupations in the department of regulatory agencies to promulgate rules and to facilitate Colorado's participation in the compact, including notification to the compact commission of any adverse action taken by the director against a Colorado audiologist or speech-language pathologist. *The bill makes the following appropriations:*

- *$108,432 and 0.3 FTE to the department of regulatory agencies from the division of professions and occupations cash fund;*
- *$17,014 and 0.1 FTE to the department of law from reappropriated funds;*
- *$60,000 to the office of the governor for use by the office of information technology from reappropriated funds; and*
- *$21,503 and 0.1 FTE to the department of public safety for use by the Colorado bureau of investigation from the Colorado bureau of investigation identification unit cash fund.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
2/17/2021 Senate Committee on Health & Human Services Refer Unamended to Appropriations
3/12/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole
3/12/2021 Senate Second Reading Special Order - Passed with Amendments - Committee
3/16/2021 Senate Third Reading Passed - No Amendments
3/17/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
4/13/2021 House Committee on Public & Behavioral Health & Human Services Refer Amended to Finance
4/26/2021 House Committee on Finance Refer Unamended to Appropriations

Concerning confirmation of receipt of a written request to perform an audit of a medicaid provider prior to the commencement of the audit.
Sponsors: J. Bridges (D) | J. Smallwood (R) / M. Snyder (D) | H. McKean (R)

The bill requires that, prior to initiating a review or audit of a medicaid ~~provider a reviewer or auditor shall confirm receipt of the written request to perform the audit or review~~ *provider's records, the reviewer or auditor, or a qualified agent contracted with the department of health care policy and financing (state department) shall confirm the provider's contact information with the provider. After confirming the provider's contact information, the reviewer or auditor, or qualified agent, shall notify the provider of additional information concerning the review or audit. Current law requires the reviewer or auditor, prior to initiating the review or audit, to deliver to the provider not less than 10 business days prior to the commencement of the audit a written request describing in detail such records and offering the provider the option of providing either a reproduction of such records or inspection at the provider's site. The bill requires the written request to be provided through both e-mail and certified mail. The bill requires the state department to ensure providers understand the relationship between the state department and the qualified agent and how to contact the qualified agent prior to a qualified agent commencing any review or audit.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
2/17/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/23/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole
4/23/2021 Senate Second Reading Special Order - Passed with Amendments - Committee
4/26/2021 Senate Third Reading Passed - No Amendments
4/26/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
5/4/2021 House Committee on Public & Behavioral Health & Human Services Refer Unamended to House Committee of the Whole

Position: Support
Concerning family planning services for individuals whose income does not exceed two hundred fifty percent of the federal poverty level.
Sponsors: B. Pettersen (D)

The bill requires the department of health care policy and financing to seek federal authorization through an amendment to the state medical assistance plan to provide family planning services to individuals who are not pregnant and whose income does not exceed 250% of the federal poverty level. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/24/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Concerning emergency supplies for Colorado babies and families, and, in connection therewith, providing diapering essentials through diaper distribution centers and making an appropriation.
Sponsors: B. Pettersen (D) | J. Danielson (D) / S. Gonzales-Gutierrez (D) | K. Tipper (D)

The bill requires the department of public health and environment to select one or more nonprofit organizations to administer diaper distribution centers that provide diapering essentials to eligible individuals. Diapering essentials must be made available to all Colorado residents. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/3/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
5/6/2021 Senate Second Reading Passed with Amendments - Committee, Floor

Concerning compliance with the "State Administrative Procedure Act" by certain state entities in the promulgation of legal standards affecting public health.
Sponsors: B. Kirkmeyer (R)

The bill clarifies that, whenever the state board of health or the Colorado department of public health and environment promulgates a rule, it shall do so by complying with the "State Administrative Procedure Act". The bill also prohibits the state board of health and the Colorado department of public health and environment from issuing an order that has the general applicability of a rule unless the state board of health or the Colorado department of public health and environment issues the order in accordance with the requirements for promulgating a rule, as set forth in the "State Administrative Procedure Act". *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/2/2021 Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely

Concerning additional procedural requirements for the issuance of emergency public health orders.
Sponsors: B. Gardner (R)

The bill requires that a state agency, in issuing an emergency public health order, comply with the procedural requirements set forth in the "State Administrative Procedure Act" (APA) that apply to emergency rules. To extend an emergency public health order beyond the 120-day limit that applies to emergency rules, the agency must comply with the rule-making procedures regarding notice and a hearing, as set forth in the APA. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/2/2021 Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely

Concerning criminalizing retaliation against an elected official, and, in connection therewith, making an appropriation.
Sponsors: L. Garcia (D) | J. Cooke (R) / K. Mullica (D)

Under current law, there is a crime of retaliation against a judge if an individual makes a credible threat or commits an act of harassment or an act of harm or injury upon a person or property as retaliation or retribution

against a judge. ~~The crime is a class 4 felony. The bill adds elected officials and their families to the crime.~~ *The bill creates a similar crime if an individual makes a credible threat or commits an act of harassment as retaliation or retribution against an elected official or the official's family. Retaliation against an elected official is a class 1 misdemeanor unless committed by means of a credible threat, then it is a class 6 felony. The bill makes following appropriations from the general fund to the department of corrections to comply with the 5-year corrections appropriation requirement:*

- *For fiscal year 2022-23 $16,279;*
- *For fiscal year 2023-24 $18,415;*
- *For fiscal year 2024-25 $18,415; and*
- *For fiscal year 2025-26 $18,415.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Judiciary + Appropriations
3/18/2021 Senate Committee on Judiciary Refer Amended to Appropriations
4/1/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
4/1/2021 Senate Second Reading Special Order - Passed with Amendments - Committee
4/5/2021 Senate Third Reading Passed - No Amendments
4/6/2021 Introduced In House - Assigned to Judiciary
4/27/2021 House Committee on Judiciary Witness Testimony and/or Committee Discussion Only
5/4/2021 House Committee on Judiciary Refer Amended to Appropriations

Concerning the elimination of verification of an individual's lawful presence in the United States as a requirement for individual credentialing.
Sponsors: J. Gonzales (D) / A. Benavidez (D) | C. Kipp (D)

The bill eliminates the requirement that the department of education and each division, board, or agency of the department of regulatory agencies verify the lawful presence of each applicant before issuing or renewing a license. The bill also specifies that lawful presence is not required of any applicant for any *state or local* license, certificate, or registration. The bill affirmatively states that the bill is a state law within the meaning of the federal law that gives states authority to provide for eligibility for state and local public benefits to persons who are unlawfully residing in the United States.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Business, Labor, & Technology
3/17/2021 Senate Committee on Business, Labor, & Technology Refer Amended to Senate Committee of the Whole
3/22/2021 Senate Second Reading Passed with Amendments - Committee
3/23/2021 Senate Third Reading Passed - No Amendments
3/25/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs

4/12/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Amended to House Committee of the Whole
4/16/2021 House Second Reading Passed with Amendments - Committee
4/21/2021 House Third Reading Passed - No Amendments
4/22/2021 Senate Considered House Amendments - Result was to Not Concur - Request Conference Committee
4/30/2021 First Conference Committee Result was to Adopt Rerevised w/ Amendments

Concerning protections for entities that comply with public health guidelines related to COVID-19.
Sponsors: R. Woodward (R) / S. Bird (D) | M. Bradfield

An entity is not liable for any damages that result from exposure, loss, damage, injury, or death arising out of COVID-19 unless:

- A claimant proves by clear and convincing evidence that the exposure, loss, damage, injury, or death was caused by the entity's failure to comply with public health guidelines; or
- The exposure, loss, damage, injury, or death was caused by gross negligence or a willful and wanton act or omission of the entity.

The bill is repealed 2 years after the date the governor terminates the state of disaster emergency declared on March 11, 2020. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Business, Labor, & Technology
3/8/2021 Senate Committee on Business, Labor, & Technology Postpone Indefinitely

3/9/2021: 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: Public programs should be excluded from actuarial review. The bill should allow for the request actuarial reviews if an insurance benefit is being cut/reduced- not just adding new benefits. 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). 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. 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. 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.
4/13/2021:The Board voted to Oppose SB21-085. While they appreciate the intent of the law, the concern is that the timing and budget would not allow for the required quality of analysis that would lead to adequate meaningful data from which to make policy decisions.
Position: Oppose
Concerning actuarial reviews of proposed legislation that may impose a new health benefit mandate on health

benefit plans.
Sponsors: J. Ginal (D) | J. Smallwood (R) / S. Lontine (D)

The bill requires the division of insurance (division) to retain a contractor on or before November 1, 2021, for the purpose of performing actuarial reviews of proposed legislation that may impose a new health benefit mandate on 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. Each actuarial review performed by the contractor must consider the predicted effects of the legislative proposal during the 5 years immediately following the effective date of the proposed legislation, including specifically described considerations. In preparing a fiscal note for any legislative proposal that may impose a new health benefit mandate on health benefit plans, the legislative service agency charged with preparing the fiscal note shall either:

- Include in the fiscal note information that is produced by the contractor in review of the legislative proposal; or
- If no information is produced by the contractor in review of the legislative proposal, indicate such fact in the fiscal note. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Finance
3/30/2021 Senate Committee on Finance Refer Amended to Appropriations
4/23/2021 Senate Committee on Appropriations Postpone Indefinitely

Concerning the expansion of breast cancer screening services provided through the department of public health and environment to include screening of other types of cancer.
Sponsors: J. Buckner (D)

Current law appropriates $5 million annually from the tobacco tax cash fund to the department of public health and environment (department) for breast and cervical cancer screenings. The bill expands the use of the funds for additional cancer screenings. The bill changes the name of the breast cancer screening fund to the cancer screening fund and authorizes the money in the fund to be used for breast and cervical cancer screenings, colorectal cancer screenings, and screenings for additional screenable cancers. The bill changes the makeup of the existing advisory board from persons interested in health care and the promotion of breast cancer screenings to include persons who are interested in health care and the promotion of services for other screenable cancers. When making recommendations to the executive director of the department concerning cancer screening services, the bill requires the advisory board to allocate, at a minimum, $2.5 million annually for breast and cervical cancer screenings, $1 million annually for colorectal cancer screenings, and, if feasible, money for screenings for additional screenable cancers. *(Note: This summary applies to this bill as introduced.)*

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
3/17/2021 Senate Committee on Health & Human Services Postpone Indefinitely

Concerning the renewal of a small group health benefit plan issued to an employer that no longer meets the definition of small employer after the small group plan was first issued.
Sponsors: J. Smallwood (R) / E. Hooton (D)

The bill clarifies that if a small employer has been issued a health benefit plan subject to small group insurance laws and rules, and then following the issuance date ~~no longer meets the definition of "small employer"~~ *subsequently employs more than 100 employees* , the small group insurance laws and rules continue to apply to the plan as long as the employer renews the current health benefit plan. If the employer opts to renew its current plan, the bill requires an insurance carrier to offer the employer the same small group health benefit plan or, if the same plan is no longer available, a similar plan that the carrier offers to other small employers. The bill requires an insurance carrier to notify the employer that the small group insurance laws and rules will no longer apply if the employer fails to renew the current plan or elects to enroll in a different health benefit plan.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.)(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/16/2021 Introduced In Senate - Assigned to Health & Human Services
2/22/2021 Senate Committee on Health & Human Services Refer Amended - Consent Calendar to Senate Committee of the Whole
2/25/2021 Senate Second Reading Passed with Amendments - Committee
2/26/2021 Senate Third Reading Passed - No Amendments
3/1/2021 Introduced In House - Assigned to Health & Insurance
3/9/2021 House Committee on Health & Insurance Refer Unamended to House Committee of the Whole
3/11/2021 House Second Reading Special Order - Passed - No Amendments
3/16/2021 House Third Reading Passed - No Amendments
3/18/2021 Sent to the Governor
3/25/2021 Governor Signed

Concerning the bulk purchase of opiate antagonists pursuant to a standing order.
Sponsors: J. Ginal (D) / M. Froelich (D)

Current law allows specific entities to purchase opiate antagonists through the opiate antagonist bulk purchase fund (fund) and also allows specific entities to receive opiate antagonists pursuant to standing orders and protocols. The bill aligns these sections of law so that:

- A unit of local government may purchase opiate antagonists through the fund pursuant to a standing order and protocol; and
- A harm reduction organization, law enforcement agency, or first responder to which opiate antagonists have been prescribed or dispensed through a standing order and protocol may purchase the opiate antagonists through the fund. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/23/2021 Introduced In Senate - Assigned to Health & Human Services
3/10/2021 Senate Committee on Health & Human Services Refer Unamended to Senate Committee of the Whole
3/12/2021 Senate Second Reading Special Order - Passed - No Amendments
3/16/2021 Senate Third Reading Passed - No Amendments
3/17/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services
3/30/2021 House Committee on Public & Behavioral Health & Human Services Refer Unamended to House

Committee of the Whole
4/1/2021 House Second Reading Passed - No Amendments
4/5/2021 House Third Reading Passed - No Amendments
4/8/2021 Sent to the Governor
4/15/2021 Governor Signed

Concerning expanding the Canadian prescription drug importation program to include prescription drug suppliers from nations other than Canada upon the enactment of legislation by the United States congress authorizing such practice.
Sponsors: J. Ginal (D) | D. Coram (R) / K. McCormick (D) | M. Lynch (R)

In 2019, the Colorado general assembly enacted, and the governor subsequently signed into law, the Canadian prescription drug importation program (program) in the department of health care policy and financing (department). The bill states that the department may expand the program to allow a manufacturer, wholesale distributor, or pharmacy from a nation other than Canada to export prescription drugs into the state under the program if certain conditions are met. If, upon the satisfaction of these conditions, the department decides to expand the program, the executive director of the department shall notify the president of the senate, the speaker of the house of representatives, and specified legislative committees, of the department's intent to do so. The executive director shall provide the notice at least 30 days before the program is expanded, and the notice may include any recommendations of the department for legislation to amend the program to reflect its expansion. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/25/2021 Introduced In Senate - Assigned to Health & Human Services
3/8/2021 Senate Committee on Health & Human Services Refer Unamended to Senate Committee of the Whole
3/11/2021 Senate Second Reading Passed - No Amendments
3/12/2021 Senate Third Reading Passed - No Amendments
3/17/2021 Introduced In House - Assigned to Health & Insurance
4/7/2021 House Committee on Health & Insurance Refer Unamended to House Committee of the Whole
4/12/2021 House Second Reading Passed - No Amendments
4/13/2021 House Third Reading Passed - No Amendments
4/16/2021 Sent to the Governor
4/26/2021 Governor Signed

Concerning credentialing of physicians as participating physicians in health coverage plan provider networks, and, in connection therewith, making an appropriation.
Sponsors: R. Fields (D) / D. Michaelson Jenet (D)

The bill requires that when a physician applies to be credentialed as a participating physician in a health insurance carrier's (carrier's) provider network, the carrier must conclude the process of credentialing the applicant within 60 calendar days after the carrier receives the applicant's completed application. A carrier must provide each applicant written or electronic notice of the outcome of the applicant's credentialing within 10 calendar days after the conclusion of the credentialing process. Within 7 calendar days after a carrier receives an application, the carrier must provide the applicant a receipt. If a carrier receives an application but fails to provide the applicant a receipt within 7 calendar days, the carrier shall consider the applicant a participating physician, effective no later than 53 calendar days following the carrier's receipt of the application.

A carrier may not deny a claim for a medically necessary covered service provided to a covered person if the service:

- Is a covered benefit under the covered person's health coverage plan; and
- Is provided by a participating physician who is in the provider network for the carrier's health coverage plan and has concluded the carrier's credentialing process.

A carrier may not require a participating physician to submit an application or participate in a contracting process in order to be recredentialed. *With certain exceptions, a* carrier must allow a participating physician to remain credentialed and include the participating physician in the carrier's provider network unless the carrier discovers information indicating that the participating physician no longer satisfies the carrier's guidelines for participation. The commissioner of insurance is required to enforce the new requirements. A carrier that fails to comply with the bill or with any rules adopted pursuant to the bill is subject to such civil penalties as the commissioner may order. *To implement the bill, for the 2021-22 state fiscal year, the bill appropriates $52,505 to the department of regulatory agencies from the division of insurance cash fund. Of this amount, $21,268 is reappropriated to the department of law for legal services.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
2/25/2021 Introduced In Senate - Assigned to Health & Human Services
3/8/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/23/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
4/27/2021 Senate Second Reading Passed with Amendments - Committee
4/28/2021 Senate Third Reading Passed - No Amendments
4/30/2021 Introduced In House - Assigned to Health & Insurance

Concerning the authority of a regulator of health care professionals during a disaster emergency declared by the governor.
Sponsors: J. Ginal (D) / K. Mullica (D)

The bill authorizes the director of the division of professions and occupations or the applicable regulatory board in the department of regulatory agencies (regulator) to suspend or waive statutes or rules governing a health care profession or occupation over which a regulator has authority during a disaster emergency declared by the governor. The suspension or waiver of a statute or rule is limited to those in which strict compliance would prevent, hinder, or delay necessary action in coping with or responding to the disaster emergency and may not suspend, waive, or modify any supervisory requirements. The bill allows a regulator to promulgate emergency rules commensurate with the nature of the disaster emergency and within the limits of the declaration and the applicable practice act for a health care profession or occupation. The emergency rules automatically expire 60 days after the termination of the declared disaster emergency. *(Note: This summary applies to this bill as introduced.)*

Status
2/25/2021 Introduced In Senate - Assigned to Business, Labor, & Technology
3/17/2021 Senate Committee on Business, Labor, & Technology Postpone Indefinitely

Concerning establishing a pilot program to reduce the suicide rate among veterans.
Sponsors: L. Garcia (D) / D. Ortiz

The bill requires the state department of human services (department) to establish a veteran suicide prevention pilot program (pilot program) to reduce the suicide rate and suicidal ideation among veterans by providing no-cost, stigma-free, confidential, and effective behavioral health treatment for post-9/11 veterans and their families. The department is permitted to enter into an agreement with a nonprofit organization to administer the pilot program. The department is required to include information about the pilot program in its annual report to the general assembly. The pilot program is repealed June 30, 2025. *(Note: This summary applies to this bill as introduced.)*

Status
2/25/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/18/2021 Senate Committee on State, Veterans, & Military Affairs Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole

Concerning authorization for local governments to exempt business personal property from taxation.
Sponsors: C. Holbert (R) | B. Pettersen (D) / K. Van Winkle (R) | S. Bird (D)

The bill allows counties, municipalities, and special districts to exempt up to 100% of business personal property from the levy and collection of property taxation for the 2021 property tax year. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
2/25/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/18/2021 Senate Committee on State, Veterans, & Military Affairs Refer Unamended - Consent Calendar to Senate Committee of the Whole
3/22/2021 Senate Second Reading Passed - No Amendments
3/23/2021 Senate Third Reading Passed - No Amendments
3/24/2021 Introduced In House - Assigned to Transportation & Local Government
4/7/2021 House Committee on Transportation & Local Government Refer Amended to House Committee of the Whole
4/12/2021 House Second Reading Passed with Amendments - Committee
4/13/2021 House Third Reading Passed - No Amendments
4/14/2021 Senate Considered House Amendments - Result was to Concur - Repass
4/20/2021 Sent to the Governor
4/29/2021 Governor Signed

Concerning the "Behavioral Health Recovery Act of 2021", and, in connection therewith, making an appropriation.
Sponsors: B. Pettersen (D) / D. Michaelson Jenet (D) | C. Kennedy (D)

Section 1 of the bill titles the bill the "Behavioral Health Recovery Act of 2021". **Section 2** of the bill continues the requirement that a podiatrist must adhere to the limitations on prescribing opioids.**Sections 3 and 4** of the bill continue the funding for the medication-assisted treatment expansion pilot program (pilot program) for the

2020-21 through 2022-23 state fiscal years and repeal the pilot program on June 30, 2023.**Section 5** of the bill expands the Colorado state university AgrAbility project (project) by providing funding for the project's rural rehabilitation specialists to provide information, services, and research-based, stress-assistance information, education, suicide prevention training, and referrals to behavioral health-care services to farmers, ranchers, agricultural workers, and their families to mitigate incidences of harmful responses to stress experienced by these individuals.**Section 6** of the bill appropriates money to the department of public health and environment to address behavioral health disorders through public health prevention and intervention and to work with community partners to address behavioral health, mental health, and substance use priorities throughout the state.**Section 7** of the bill continuously appropriates money to the harm reduction grant program.**Section 8** of the bill requires a managed care organization (MCO) to notify a person's provider of approval of authorization of services no later than 24 hours after the submission of the request for services. The initial authorization for intensive residential treatment must be no less than 7 days, and the initial authorization for transitional residential treatment must be no less than 14 days. The initial authorization period may be longer if the MCO does not have sufficient information from the person's provider. MCOs shall continually authorize services in accordance with the person's provider if the MCO's determination conflicts with the provider's recommendation. MCOs shall provide specific justification for each denial of continued authorization for all 6 dimensions in the most recent edition of "The ASAM Criteria for Addictive, Substance-related, and Co-occuring Conditions".**Section 9** of the bill requires the state medical assistance program (medicaid) to include screening for perinatal mood and anxiety disorders for each child enrolled in medicaid in accordance with the health resources and services administration guidelines. The screening must be made available to any person, regardless of whether the person is enrolled in medicaid, so long as the person's child is enrolled in medicaid. **Section 10** of the bill requires the department of human services to develop a statewide data collection and information system to analyze implementation data and selected outcomes to identify areas for improvement, promote accountability, and provide insights to continually improve child and program outcomes.**Section 11** of the bill requires the department of human services, in collaboration with the department of agriculture, to contract with a nonprofit organization primarily focused on serving agricultural and rural communities in Colorado to provide vouchers to individuals living in rural and frontier communities in need of behavioral health-care services.**Section 12** of the bill requires the center for research into substance use disorder prevention, treatment, and recovery support strategies to engage in community engagement activities to address substance use prevention, harm reduction, criminal justice response, treatment, and recovery.**Section 13** of the bill continues the building substance use disorder treatment capacity in underserved communities grant program.**Section 14** of the bill requires the perinatal substance use data linkage project to utilize data from multiple state-administered data sources when examining certain issues related to pregnant and postpartum women with substance use disorders and their infants.**Section 15** of the bill requires the office of behavioral health to use a competitive selection process to select a recovery residence certifying body to certify recovery residences and educate and train recovery residence owners and staff on industry best practices. **Section 16** of the bill requires the office of behavioral health to establish a program to provide temporary financial housing assistance to individuals with a substance use disorder who have no supportive housing options when the individual is transitioning out of a residential treatment setting and into recovery or receiving treatment for the individual's substance use disorder.**Section 16** of the bill also creates the recovery support services grant program for the purpose of providing recovery-oriented services to individuals with a substance use and co-occurring mental health disorder.**Section 17** of the bill continues the appropriation to the maternal and child health pilot program.**Section 18** of the bill continues the program to increase public awareness concerning the safe use, storage, and disposal of opioids and the availability of nalaxone and other drugs used to block the effects of an opioid overdose.**Section 19** of the bill continues the harm reduction grant program and the maternal and child health pilot program.**Section 20** of the bill appropriates money to various state departments for certain programs. *(Note: This summary applies to this bill as introduced.)*

Status

3/1/2021 Introduced In Senate - Assigned to Health & Human Services

3/31/2021 Senate Committee on Health & Human Services Witness Testimony and/or Committee Discussion Only
4/5/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Concerning reimbursement for dental care services provided through telehealth.
Sponsors: R. Fields (D) | C. Simpson / S. Lontine (D) | M. Soper (R)

The bill requires each dental plan issued, amended, or renewed in this state to cover services offered to a covered person through telehealth. *The bill also requires the state's medical assistance program to reimburse providers for dental care services provided through telehealth.*

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
3/1/2021 Introduced In Senate - Assigned to Health & Human Services
3/22/2021 Senate Committee on Health & Human Services Refer Amended - Consent Calendar to Senate Committee of the Whole
3/25/2021 Senate Second Reading Passed with Amendments - Committee
3/26/2021 Senate Third Reading Passed - No Amendments
3/30/2021 Introduced In House - Assigned to Health & Insurance
4/20/2021 House Committee on Health & Insurance Refer Unamended to House Committee of the Whole
4/23/2021 House Second Reading Passed with Amendments - Committee
4/26/2021 House Third Reading Passed - No Amendments
4/29/2021 Sent to the Governor

Position: Support
Concerning the implementation of the 988 national suicide prevention lifeline network in Colorado.
Sponsors: C. Kolker (D) | C. Simpson (R) / L. Cutter (D) | M. Soper (R)

On October 17, 2020, congress passed the "National Suicide Hotline Designation Act of 2020" designating 988 as the 3-digit number for the national suicide prevention lifeline to aid rapid access to suicide prevention and mental health support services. The bill implements 988 as the 3-digit number for crisis response services in Colorado. On or before July 1, 2022, the department of human services (department) shall contract with a nonprofit organization to create the 988 crisis hotline center to provide intervention services and crisis care coordination to individuals calling the 988 crisis hotline 24 hours a day, 7 days a week. Beginning January 1, 2022, a 988 surcharge (surcharge) is imposed on service users in an amount to be established by the public utilities commission (commission) on an annual basis. The bill requires each service supplier to collect the surcharge from its service users and remit the collected surcharges to the commission on a monthly basis. The state treasurer shall credit the surcharge collections to the 988 surcharge cash fund (fund). The bill imposes a prepaid wireless 988 charge on each retail transaction in an amount to be established by the commission on an annual basis. The bill requires each seller to collect the prepaid wireless 988 charge from the consumer on each retail transaction occurring in the state and remit the collected charges to the department of revenue. The state treasurer shall credit the prepaid wireless 988 charge to the fund. The office of behavioral health in the department may expend money from the fund for the administration and operation of the 988 crisis hotline

center. Beginning January 1, 2023, and each January 1 thereafter, the department shall submit information about the usage of the 988 crisis hotline center to the federal substance abuse and mental health services administration, and information about the expenditures of the fund to the federal communications commission. *(Note: This summary applies to this bill as introduced.)*

Status
3/1/2021 Introduced In Senate - Assigned to Health & Human Services
4/7/2021 Senate Committee on Health & Human Services Refer Amended to Finance
4/28/2021 Senate Committee on Finance Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole

Concerning the creation of a pilot grant program for the use of nurses in 911 dispatch to help divert incoming 911 calls that do not require emergency medical service to other types of medical care.
Sponsors: L. Garcia (D) / K. Mullica (D)

The bill requires the division of homeland security and emergency management in the department of public safety (division), on or before January 1, 2022, to implement a pilot grant program (program) to help finance the use of nurse intake of 911 calls, which involves nurses assisting with 911 dispatch for the purpose of diverting nonurgent 911 calls to medical care that does not require ambulance service or treatment in an emergency room. The division, after reviewing applications, shall designate 4 public safety answering points to participate in the program, one of which is located in a county with 60,000 or more residents and 3 of which are located in a county or counties with fewer than 60,000 residents. To participate in the program, the designated public safety answering points must each enter into a contract with an entity that can provide nurses who are trained and equipped to provide nurse intake of 911 calls. On or before June 1, 2023, the division shall report to the judiciary committees in the senate and the house of representatives or their successor committees on the program. *(Note: This summary applies to this bill as introduced.)*

Status
3/1/2021 Introduced In Senate - Assigned to Health & Human Services
3/24/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Concerning modifications to the Colorado health service corps program administered by the department of public health and environment to expand the availability of geriatric care providers in shortage areas in the state.
Sponsors: J. Danielson (D) | B. Pettersen (D) / B. Titone (D) | M. Duran (D)

The bill modifies the Colorado health service corps program administered by the primary care office (office) in the department of public health and environment, which program includes a loan repayment program, as follows:

- Allows geriatric advanced practice providers, which include advanced practice registered nurses and physician assistants with geriatric training or experience, to participate in the loan repayment program on the condition of committing to provide geriatric care to older adults in health professional shortage areas for a specified period; and

- Requires the general assembly to annually and continuously appropriate money from the general fund to the office for the 2021-22 through the 2025-26 fiscal years to help repay loans for geriatric advanced practice providers. *(Note: This summary applies to this bill as introduced.)*

Status
3/1/2021 Introduced In Senate - Assigned to Health & Human Services
3/22/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations

Concerning certain administrative clarifications to local government election codes.
Sponsors: B. Gardner (R) / M. Snyder (D)

The bill makes the following changes to the local government and special district election codes:

- Revises statutory citations to clarify that the Colorado local government election code is the portion of the election code applicable to special district elections;
- Provides additional statutory citations to specify all instances in which a county assessor provides a list of property owners for an election;
- Clarifies that, when computing time for any designated period of days for a local government election, the first day from which the period of days runs is excluded and the last day from which the period of days runs is included;
- Specifies that the candidate self-nomination form for special district elections must contain the county where the special district is located;
- Clarifies that a candidate's and witness's respective addresses and telephone numbers and a candidate's current e-mail address need to be provided but do not need to be printed by the candidate and witness on the self-nomination form for special district elections;
- *Clarifies the procedures for reviewing and verifying a self-nomination form and curing any insufficiencies; and*
- ~~Specifies that an eligible elector of a local government who is a covered voter must reside within the boundaries of the local government to receive a mail ballot;~~
- Clarifies that local government ballots may be automatically sent to eligible electors who are qualified under contracts to purchase taxable property. ~~and~~
- ~~Eliminates provisions governing a self-affirming oath or affirmation of an elector in the statutes governing special districts that are covered by similar provisions in the election code.~~

The board of directors of a special district currently consists of 5 or 7 directors elected at large. The bill provides a process for dividing a special district into separate director districts and for members to be elected from each director district at large or by the electors within each director district.

(Note: Italicized words indicate new material added to the original summary; dashes through words indicate deletions from the original summary.) (Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status
3/2/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/23/2021 Senate Committee on State, Veterans, & Military Affairs Refer Amended - Consent Calendar to Senate Committee of the Whole
3/26/2021 Senate Second Reading Passed with Amendments - Committee, Floor
3/30/2021 Senate Third Reading Passed - No Amendments

3/31/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs
4/29/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Unamended to House Committee of the Whole
5/3/2021 House Second Reading Passed - No Amendments
5/4/2021 House Third Reading Passed - No Amendments
5/6/2021 Sent to the Governor

Concerning protecting consumers from unfair discrimination in insurance practices.
Sponsors: J. Buckner (D)

An insurer is prohibited from:

- Considering an individual's race, color, national or ethnic origin, religion, sex, sexual orientation, disability, or transgender status in any insurance practice; or
- Directly or indirectly using any external consumer data and information source, algorithm, or predictive model (external data source) that unfairly discriminates against an individual based on an individual's race, color, national or ethnic origin, religion, sex, sexual orientation, disability, or transgender status.

On and after January 1, 2022, an insurer that uses one or more external data sources in any insurance practice shall submit certain disclosures to the division of insurance. The commissioner of insurance (commissioner) may examine and investigate an insurer's use of an external data source. If the commissioner determines that use of an external data source bears no direct causal relationship to insurance losses or to the condition of a property or applicant to be potentially insured and that the use of the external data source unfairly discriminates on the basis of an individual's membership in a protected class, the commissioner may promulgate rules restricting or prohibiting the use of the external data source. *(Note: This summary applies to this bill as introduced.)*

Status
3/2/2021 Introduced In Senate - Assigned to Business, Labor, & Technology
5/3/2021 Senate Committee on Business, Labor, & Technology Refer Amended to Senate Committee of the Whole

Position: Strongly Support
Concerning the Colorado prescription drug affordability review board, and, in connection therewith, directing the board to review the affordability of certain drugs and establish upper payment limits for certain drugs; prohibiting certain entities from purchasing or reimbursing for any drug for distribution in the state at an amount that exceeds the upper payment limit established for the prescription drug; establishing penalties for violations; and making an appropriation.
Sponsors: S. Jaquez Lewis (D) | J. Gonzales (D) / Y. Caraveo (D) | C. Kennedy (D)

The bill creates the Colorado prescription drug affordability review board (board) as an independent unit of state government and requires the board to perform affordability reviews of prescription drugs and establish upper payment limits for prescription drugs the board determines are unaffordable for Colorado consumers. The board is also required to promulgate rules as necessary for its purposes. The board shall determine by rule the methodology for establishing an upper payment limit for a prescription drug. An upper payment limit applies to all purchases of and payer reimbursements for the prescription drug dispensed or administered to individuals in the state in person, by mail, or by other means. Any savings generated for a health benefit plan as a result of an upper payment limit established by the board must be used by the carrier that issued the health benefit plan to

reduce costs to consumers. On and after January 1, 2022, the bill prohibits any purchase or payer reimbursement for a prescription drug from exceeding an upper payment limit established by the board for that prescription drug. A person who violates the prohibition may be subject to a fine of $1,000 for each violation. Final board decisions are subject to judicial review. A person aggrieved by a decision of the board may appeal the decision within 60 days. The board shall consider the appeal and issue a final decision concerning the appeal within 60 days after the board receives the appeal. Any prescription drug manufacturer (manufacturer) that intends to withdraw a prescription drug for which the board has established an upper payment limit from sale or distribution within the state must notify, at least 180 days before the withdrawal:

- The commissioner;
- The attorney general; and
- Each entity in the state with which the manufacturer has contracted for the sale or distribution of the prescription drug.

A manufacturer who fails to comply with the notice requirement may be required to pay a penalty of up to $500,000. For all prescription drugs dispensed at a pharmacy and paid for by a carrier during the immediately preceding calendar year, the bill requires each carrier and each pharmacy benefit management firm acting on behalf of a carrier to report certain information. The bill creates the Colorado prescription drug affordability advisory council to provide stakeholder input to the board. The board must submit an annual report to the governor and to subject matter committees of the general assembly summarizing the activities of the board during the preceding calendar year. *(Note: This summary applies to this bill as introduced.)*

Status
3/8/2021 Introduced In Senate - Assigned to Health & Human Services
3/17/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
5/6/2021 Senate Second Reading Passed with Amendments - Committee, Floor

Concerning protections for Colorado workers against discriminatory employment practices.
Sponsors: F. Winter (D) | B. Pettersen (D) / S. Lontine (D) | M. Gray (D)

For purposes of addressing discriminatory or unfair employment practices pursuant to Colorado's anti-discrimination laws, the bill:

- Allows an employment discrimination claim to be brought in any court of competent jurisdiction in the county or district where the alleged discriminatory or unfair employment practice occurred and allows an individual to file a civil action, without otherwise exhausting administrative proceedings and remedies, as long as the individual either files a charge with the Colorado civil rights commission (commission) or serves a written demand for the relief on the individual's employer and allows the employer 14 days to respond;
- Expands the definition of "employee" to include individuals in domestic service; individuals who perform a service for a price, including independent contractors, subcontractors, and their employees; and individuals who offer services or labor without pay;
- Adds new definitions of "caregiver", "care recipient", "child", "minor child", "harassment", "hostile work environment", and "independent contractor";
- Adds protections from discriminatory or unfair employment practices for individuals based on their "marital status" or "caregiver status";

- Specifies that it is a discriminatory or unfair employment practice for an employer to fail to initiate an investigation of a complaint or fail to take prompt remedial action if appropriate;
- Prohibits certain preemployment medical examinations, imposes limitations on inquiries and examinations about an employee's disability during employment, and specifies that violations of these prohibitions and limitations constitute discriminatory or unfair employment practices;
- Expands the time limit to file a charge with the commission from 6 months to 300 days after the alleged discriminatory or unfair employment practice occurred;
- Repeals the limits on remedies in cases involving age discrimination; and
- Limits the ability of an employer to require confidentiality of claims once a charge is filed with the commission. *(Note: This summary applies to this bill as introduced.)*

Status
3/8/2021 Introduced In Senate - Assigned to Judiciary
5/6/2021 Senate Committee on Judiciary Refer Amended to Appropriations

Position: Support
Concerning state agencies addressing health disparities in Colorado, and, in connection therewith, making an appropriation.
Sponsors: R. Fields (D) | D. Coram (R) / L. Herod (D) | Y. Caraveo (D)

The bill renames the existing "health disparities grant program" to the "health disparities and community grant program" (program) and expands the program to authorize the office of health equity (office) to:

- Award grants from money currently transferred from the prevention, early detection, and treatment fund to the health disparities grant program fund (fund) for the purpose of positively affecting social determinants of health to reduce the risk of future disease and exacerbating health disparities in underrepresented populations; and
- Award grants from any additional money appropriated by the general assembly to the fund to community organizations to reduce health disparities in underrepresented communities through policy and systems changes regarding the social determinants of health.

On or before January 1, 2022, and continuing every 2 years thereafter, the office is required to issue a report concerning health disparities in Colorado by race and ethnicity that includes an assessment of the impact of social determinants of health on health disparities and recommended strategies to begin to address such inequities with the collaboration of the health equity commission and other stakeholders. On or before July 1, 2022, the office is required to facilitate a state agency work group to develop an equity strategic plan. Specific state agencies are required to participate in the state agency work group to ensure coordination in equity-related work across state agencies to address social determinants of health in each agency's respective area. The bill adds additional state agency executive directors to the health equity commission. *(Note: This summary applies to this bill as introduced.)*

Status
3/10/2021 Introduced In Senate - Assigned to Health & Human Services
3/31/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
5/4/2021 Senate Second Reading Passed with Amendments - Committee, Floor

5/5/2021 Senate Third Reading Passed with Amendments - Floor
5/5/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

Concerning protections for pregnant people during the perinatal period.
Sponsors: J. Buckner (D)/ L. Herod (D)

The bill:

- Requires each carrier offering medical malpractice insurance in the state to cover the insured for providing care during the entire course of a person's vaginal birth after a previous caesarian birth;
- Extends the statute of limitations from 2 years to 3 years for actions alleging lack of informed consent in cases related to a pregnant person;
- Repeals language that gives no force or effect to an advanced directive of a person who is pregnant while the person's fetus is viable;
- Requires annual reporting to the legislature on the use of restraints on a pregnant person within each jail, private contract prison, and correctional facility;
- Establishes requirements for each facility that incarcerates or has custody of people with the capacity for pregnancy;
- Requires the Colorado civil rights commission to receive reports from people alleging maternity care that is not organized for, and provided to, a person who is pregnant or in the postpartum period in a manner that is culturally congruent; maintains the person's dignity, privacy, and confidentiality; ensures freedom from harm and mistreatment; and enables informed choices and continuous support; and
- Requires each health facility that provides services related to labor and childbirth to demonstrate to the department of public health and environment that the health facility has a policy that meets certain requirements. *(Note: This summary applies to this bill as introduced.)*

Status
3/22/2021 Introduced In Senate - Assigned to Judiciary
4/22/2021 Senate Committee on Judiciary Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

The Board voted to strongly support the section that requires Colorado's Children's Health Plan Plus and Medicaid seek federal allowance to provide 12 months of postpartum coverage.
The Board voted to support the sections regarding the requirements that labor & delivery health professionals must implement best practices for interprofessional collaboration and the transfer of a pregnant person from home or a birthing center to a health facility and that CDHPE & Colorado Maternal Mortality Review Committee must make recommendations to improve numerous topics related to maternal health
The Board voted to remain neutral on the section that requires health plans and Medicaid to reimburse labor & delivery health professionals in a way that promotes high-quality, cost-effective care, prevents risk in subsequent pregnancy, and does not discriminate based on the type of provider or facility
Concerning maternal health.
Sponsors: J. Buckner (D) / L. Herod (D)

The bill:

- Requires a carrier offering a health benefit plan in the state, and the department of health care policy and financing when administering the "Colorado Medical Assistance Act", to reimburse health-care providers that provide health-care services related to labor and delivery in a way that promotes high-quality, cost-effective care, prevents risk in subsequent pregnancy, and does not discriminate based on the type of provider or facility;
- Requires each health-care provider licensed by the state to provide health-care services related to labor and delivery to implement best practices for interprofessional collaboration and the transfer of a pregnant person from home or a birthing center to a health facility;
- Requires the health equity commission in the department of public health and environment to study the use of research evidence in policies related to the perinatal period in Colorado and report findings to the general assembly;
- Requires the department of public health and environment to make recommendations to improve numerous topics related to maternal health; and
- Requires the department of health care policy and financing to seek an amendment to the state medical assistance plan to provide 12 months of postpartum medical benefits to persons who qualified for benefits while pregnant. *(Note: This summary applies to this bill as introduced.)*

Status
3/22/2021 Introduced In Senate - Assigned to Health & Human Services
4/14/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Position: Strongly Support
Concerning measures to remove barriers to certain public opportunities.
Sponsors: S. Jaquez Lewis (D) | F. Winter (D) / D. Esgar (D) | S. Gonzales-Gutierrez (D)

The bill repeals existing provisions that require a person to demonstrate the person's lawful presence in the United States to be eligible for certain public benefits and requires that lawful presence is not a requirement of eligibility for state or local public benefits, as defined by 8 U.S.C. sec. 1621. The bill amends statutory provisions that still require lawful presence to clarify acceptable documents to demonstrate eligibility. The general assembly shall not allocate additional funding to any state or local public benefit program for this purpose for fiscal year 2021-22. However, starting for fiscal year 2022-23, any additional funding required for a state or local public benefit program for this purpose is subject to the standard budget process for the applicable program. 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 and associated statutory provisions. *(Note: This summary applies to this bill as introduced.)*

Status
3/26/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
4/22/2021 Senate Committee on State, Veterans, & Military Affairs Refer Amended to Appropriations

Concerning the provision for payment of the expenses of the executive, legislative, and judicial departments of the state of Colorado, and of its agencies and institutions, for and during the fiscal year beginning July 1, 2021,

except as otherwise noted.
Sponsors: D. Moreno (D) / J. McCluskie (D)

Provides for the payment of expenses of the executive, legislative, and judicial departments of the state of Colorado, and of its agencies and institutions, for and during the fiscal year beginning July 1, 2021, except as otherwise noted. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
4/5/2021 Introduced In Senate - Assigned to Appropriations
4/6/2021 Senate Committee on Appropriations Refer Unamended to Senate Committee of the Whole
4/8/2021 Senate Second Reading Passed with Amendments - Floor
4/9/2021 Senate Third Reading Passed - No Amendments
4/9/2021 Introduced In House - Assigned to Appropriations
4/13/2021 House Committee on Appropriations Refer Amended to House Committee of the Whole
4/14/2021 House Second Reading Special Order - Passed with Amendments - Floor
4/15/2021 House Third Reading Passed - No Amendments
4/16/2021 Senate Considered House Amendments - Result was to Not Concur - Request Conference Committee
4/29/2021 First Conference Committee Result was to Adopt Reengrossed w/ Amendments
4/30/2021 House Consideration of First Conference Committee Report result was to Adopt Committee Report - Repass
4/30/2021 Senate Consideration of First Conference Committee Report result was to Adopt Committee Report - Repass

Position: Strongly Support
Concerning the removal of certain measures related to the reduction of the adult dental benefit enacted in House Bill 20-1361, and, in connection therewith, making an appropriation.
Sponsors: D. Moreno (D) / L. Herod (D)

Joint Budget Committee. The bill eliminates certain measures that reduce the adult dental benefit. The bill requires the state treasurer to transfer money from the general fund to the unclaimed property trust fund to repay the unclaimed property trust fund for money transferred from it to the general fund in the 2020-21 fiscal year from savings from the reduction of the adult dental benefit in the medical assistance program. The bill makes an appropriation.*(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*

Status
4/5/2021 Introduced In Senate - Assigned to Appropriations
4/6/2021 Senate Committee on Appropriations Refer Unamended to Senate Committee of the Whole
4/8/2021 Senate Second Reading Passed - No Amendments
4/9/2021 Senate Third Reading Passed - No Amendments
4/9/2021 Introduced In House - Assigned to Appropriations
4/13/2021 House Committee on Appropriations Refer Unamended to House Committee of the Whole
4/15/2021 House Second Reading Special Order - Passed - No Amendments
4/19/2021 House Third Reading Passed - No Amendments
4/27/2021 Sent to the Governor
5/4/2021 Governor Signed

Concerning the statewide communication system for referral to behavioral health services, and, in connection therewith, making an appropriation.
Sponsors: C. Kolker (D) | R. Zenzinger (D) / J. Amabile (D) | T. Van Beber (R)

The bill expands the necessary human referral services authorized by the Colorado 2-1-1 collaborative (collaborative) to include necessary referrals for behavioral health services and other resources in the state for Coloradans, particularly for individuals who are unemployed, regardless of whether they receive benefits. The bill requires the department of human services' office of behavioral health to contract with the collaborative to hire and train specialized personnel. The bill also requires the office of behavioral health to collaborate with the collaborative to engage in targeted marketing and outreach, and to ensure the marketing and outreach are targeted to traditionally underserved communities, such as immigrant, low-income, and communities of color. The bill also requires the collaborative to coordinate with the department of labor and employment (department) to target, conduct outreach, and market to individuals who are unemployed, regardless of whether they receive benefits, and may need referrals for behavioral health services and other resources. The department is required to update its unemployment application web page and specified websites to include contact information for the collaborative. The bill makes an appropriation. *(Note: This summary applies to this bill as introduced.)*

Status
4/12/2021 Introduced In Senate - Assigned to Health & Human Services
4/26/2021 Senate Committee on Health & Human Services Refer Amended to Appropriations
5/7/2021 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole
5/7/2021 Senate Second Reading Special Order - Passed with Amendments - Committee

Position: Support
Concerning the expansion of the allowable uses of the housing development grant fund, and, in connection therewith, making an appropriation.
Sponsors: J. Gonzales (D) | B. Pettersen (D) / S. Gonzales-Gutierrez (D) | S. Woodrow (D)

The bill allows the division of housing within the department of local affairs to use the housing development grant fund for rental assistance, tenancy support service programs, and awarding grants and loans for the purchase of underutilized hotels, underutilized motels, and other underutilized properties. The bill expands those who are eligible to benefit from the rental assistance and tenancy support programs to include individuals experiencing homelessness. The bill also transfers $15 million from the general fund to the housing development grant fund for the funding of rental assistance and tenancy support programs for individuals experiencing homelessness related to underutilized hotels, underutilized motels, and other underutilized properties, and the awarding of grants and loans for the purchase of underutilized hotels, underutilized motels, and other underutilized properties. Finally, the bill requires the department of local affairs, during its annual report to the assigned committee of reference, to report on the rental and tenancy support service programs provided by the division of housing for individuals experiencing homelessness related to underutilized hotels, underutilized motels, and other underutilized properties and the grants and loans awarded by the division in relation to the rental, acquisition, or renovation of underutilized hotels, underutilized motels, and other underutilized properties. *(Note: This summary applies to this bill as introduced.)*

Status
4/12/2021 Introduced In Senate - Assigned to Local Government

Position: Support
Concerning annual appropriations to the department of public health and environment.
Sponsors: D. Moreno (D) / J. McCluskie (D)

For each of the 2021-22, 2022-23, and 2023-24 state fiscal years, the bill requires the general assembly to appropriate $21,090,149 to the department of public health and environment as follows:

- $10,000,000 for distributions to local public health agencies; and
- $11,090,149 for disease control and public health response. *(Note: This summary applies to this bill as introduced.)*

Status
4/13/2021 Introduced In Senate - Assigned to Appropriations
4/30/2021 Senate Committee on Appropriations Refer Amended to Health & Human Services
5/5/2021 Senate Committee on Health & Human Services Refer Unamended to Appropriations

MEMO

TO: Health District Board of Directors

FROM: Carol Plock, Executive Director

DATE: May 7, 2021

RE: Whether to Continue to Be a Signatory in the LETA IGA

What is LETA?
Larimer Emergency Telephone Authority, LETA911, is the Governing Authority for 9-1-1 in Larimer County Colorado. LETA911 provides oversight to 9-1-1, the equipment, and the programs funded by LETA. Within this county region there are five 9-1-1 call centers, 25 government entities, one State University, and one National Park.

If you live, work, or are visiting Larimer County, you are covered by LETA's programs, their emergency alert system, and various other programs like Text to 9-1-1, that are available in our area.

The Question
The Intergovernmental Agreement that covers LETA is in the process of being revised. We have been contacted to consider whether we choose to remain in the IGA. The question is this: Should the Health District continue to be a participant and signatory in the LETA Intergovernmental Agreement?

History *(adapted from the LETA website)*
IN 1981, the Colorado Legislature authorized the creation of emergency telephone authorities. The legislation allowed for governing bodies in Colorado to join through intergovernmental agreement (IGA) to provide emergency telephone services.

In 1990, the cities, towns, county, fire and hospital districts in Larimer County signed an IGA forming the Larimer Emergency Telephone Authority (LETA). It was decided that the LETA Board should consist of equal representation of the government partners. Leadership at the time decided that the County should have one seat on the Board, and each City should have one seat. The towns would share two seats, the fire districts would share one seat, and the hospital districts would share one seat. This equated to a 7-member board representing all government partners. The LETA Board set their surcharge at $.50, later lowered to $.45.

The IGA was amended in 1999, and in 2008, LETA contracted with Everbridge to provide an emergency notification system. Multiple other upgrades and service additions (including local training of dispatchers) were completed over the years. The IGA was amended again in 2009.

In 2019, The LETA board raise the 9-1-1 surcharge in Larimer County, Colorado from $.45 per month, per phone line, to $.70 per month, per phone line.

Considerations; Reasons to Continue
Although the Health District of Northern Larimer County was not an emergency services provider (in the same way that ambulance/emergency medical services, law enforcement, and fire response are)after the privatization of Poudre Valley Health Care in 1994, the Health District has been included in both of the amendments to the IGA. The representation from hospital (now health) districts on the LETA board has typically been from health districts providing EMS services.

Being included in the IGA does not create any financial obligation on the part of the Health District, nor does it hold back or have a negative impact on LETA in any way.

Reasons to consider continuing include:

1) Acknowledgement of the Health District as a partner local government entity with a legitimate interest in emergency and disaster response.
2) Should we or UCHealth EMS services have any questions or concerns, partner status may allow a more direct line for communication and discussion.
3) Opportunity to be kept in the loop of updates and issues.
4) Should the Health District need to use Everbridge for emergency notification, partner status might expedite it.