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, March 9, 2021
4:00 p.m.

Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS SPECIAL MEETING
March 9, 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
  - HB21-1021: Peer Support Professionals Behavioral Health
  - HB21-1054: Housing Public Benefit Verification Requirement
  - SB21-011: Pharmacist Prescribe Dispense Opiate Antagonist
  - SB21-016: Protecting Preventive Health Care Coverage
  - SB21-085: Actuarial Review Health Insurance Mandate Legislation
  - SB21-xxx: Prescription Drug Affordability Board

  Federal Policy Issues
  - COVID Relief (Stimulus Package)

  Other policy issues that may arise

- **Vaccine Equity Project .....Karen Spink, MJ Jorgensen**

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

- **Brief Status Update, COVID and the Health District.....Carol Plock**
- **Board Member Replacement Update.....Carol Plock**

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

- **March 9, 4:00 pm – Board of Directors Special Meeting**
- **March 23, 4:00 pm – Board of Directors Regular Meeting**
- **April 13, 4:00 pm – Board of Directors Special Meeting**
- **April 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/tJcvce-hqj8jGtDOHxgy7I4Ck11SQi0blAOU

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

3/5/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB21-1021: PEER SUPPORT PROFESSIONALS BEHAVIORAL HEALTH

Concerning supporting the peer support professional workforce.

Details

Bill Sponsors:	House – *Pelton (R) & Caraveo (D),* Cutter (D), Kennedy (D), Larson (R), Michaelson Jenet (D), Young (D) Senate – None
Committee:	House Public & Behavioral Health & Human Services
Bill History:	2/16/2021- Introduced in House
Next Action:	3/9/2021- Hearing in House Public & Behavioral Health & Human Services Committee

Bill Summary

The bill requires the Department of Human Services (DHS) to establish procedures to approve recovery support services organizations for reimbursement of peer support professional services. The bill permits a recovery support services organization to bill Medicaid for eligible peer support services and allows HCPF to reimburse those organizations. Additionally, recovery-centered language is added in multiple different behavioral health related statute.

Issue Summary

Peer Support Workers

Peer support workers work with people in recovery to assist them in following their own recovery paths.[1] They bring in their own lived experience of living with mental health disorders or substance use disorders (SUDs) in order to support others' progress to recovery. Peer support workers may practice in a variety of practice settings from recovery residences to criminal justice settings. Research compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) has found that peer support increases self-esteem and confidence, the sense that treatment is responsive and inclusive of needs, the sense of hope and inspiration, engagement in self-care and wellness as well as decreases psychotic symptoms, reduces hospital admission rates, and decreases substance use and depression.

Core Competencies for Peer Support Workers

SAMHSA has outlined core competencies as foundational principles.[2]

- **Recovery-oriented:** Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
- **Person-centered**: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, needs, and preferences of the people served.
- **Voluntary**: Peer workers are partners or consultants to those they serve. Participation in peer recovery support services is always contingent on peer choice.

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[1] SAMHSA (2017) *Value of Peers.* Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

[2] SAMHSA (April 16, 2020). *Core Competencies for Peer Workers*. Retrieved from https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers

- **Relationship-focused**: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided.
- **Trauma-informed**: Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Peer Support in Other States

As of 2018, 39 states allowed Medicaid billing for any type (mental health or SUD) of peer support services.[3] Currently, Medicaid in Colorado is restricted to reimbursing peer-delivered services in facilities such as community mental health centers or substance use treatment facilities. According to a 2019 analysis of state Medicaid fee schedules, peer services are reimbursed an average of $13.08 for 15 minutes, with a range of $5.89 (South Carolina) to $24.36 (Georgia). The Arkansas General Assembly enacted legislation in 2019 authorizing individuals with prior drug-related offenses to work as peer support specialists. They must obtain certification in peer recovery by the Arkansas Substance Abuse Certification Board.[4] Montana enacted legislation allowing certified behavioral health peer support services to qualify as medical assistants under the state Medicaid program.[5]

This Legislation

Legislative Declaration

The General Assembly finds and declares the following statements. Peer support professionals help people achieve their recovery goals through shared understanding, respect, and empowerment. Peer support offers a form of acceptance, understanding, and validation not often found in other professional relationships. The federal Centers for Medicare and Medicaid Services recognize that peer support professionals can be an important component in a state's delivery of effective mental health and substance use disorder treatment. Peer support services can cut hospitalizations, increase a person's engagement in self-care and wellness, and help to decrease a person's psychotic symptoms. The COVID-19 pandemic has exacerbated Colorado's existing behavioral health workforce shortage, particularly in rural areas and communities of color. Colorado lacks a behavioral health workforce that reflects the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of individuals in the state. In the past two years, the number of people who have needed but not received behavioral health services has nearly doubled. Challenges to the workforce is considered the leading cause for the decreased availability of behavioral health services. Peer support professionals can help fill Colorado's workforce need. The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified peer-run organizations as an evidence-based practice. Peer-run organizations may offer a variety of services, including but not limited to: peer-run drop-in centers; recovery and wellness centers; employment services; prevention and early intervention activities; peer mentoring for children and adolescents; warm lines; or advocacy services.

Definitions

Licensed mental health provider: A licensed or certified mental health professional, including psychologists, social workers, marriage and family therapists, licensed professional counselors, unlicensed psychotherapists, addiction counselors, advanced practice registered nurses with substance use disorders

[3] Behavioral Health Workforce Research Center, School of Public Health, University of Michigan. (August 2019). Retrieved from https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

[4] 2019 AR H 1433. Retrieved from https://custom.statenet.com/public/resources.cgi?id=ID:bill:AR2019000H1433&ciq=ncsl&client_md=0750e8deac7754f06bb3750d2e9ce4fc&mode=current_text

[5] 2019 MT S 20 Retrieved from https://custom.statenet.com/public/resources.cgi?id=ID:bill:MT2019000S30&ciq=ncsl&client_md=3f601af9e0f6378b5d979f38d991ca59&mode=current_text

(SUDs) or mental health training, physician assistants with SUDs or mental health training, psychiatric technicians, medical doctors.
Peer support professional: A peer support specialist, recovery coach, peer and family recovery support specialist, peer mentor, family advocate, or family systems navigator who meets certain qualifications.
Recovery support services organization: An entity led and governed by representatives of local communities of recovery and approved by the Executive Director of the Department of Human Services (DHS).

Department of Human Services Approval

By July 1, 2022, DHS is to develop an approval procedure for recovery support services organizations. The procedures must ensure that the organization: provides recovery-focused services and supports; employs or contracts with a licensed mental health provider to administer supervision of peer support professionals; employs or contracts with peer support professionals. The peer support professionals must self- identify as having experienced recovery from a mental health disorder, SUD, and/or trauma either as a consumer or as a parent or family member. The professionals must have formal training in all core competencies for the profession as outlined by SAMHSA as well as provide nonclinical support services that align with SAMHSA recommendations.

The recovery organization must have an established process for coordinating its services with those of other agencies to ensure an uninterrupted continuum of care. DHS may require other standards for the recovery organization through rule, in collaboration with HCPF. Peer support professionals may provide services for a recovery organization in various clinical and nonclinical settings including: justice-involved settings, physical health settings, emergency departments, telehealth, agencies serving individuals experiencing homelessness, peer respite homes, and school-based health center.

DHS is to charge a fee to cover implementation expenses and processing applications of recovery organizations. The amount cannot exceed the amount to recover all indirect and direct costs with those activities. The collected funds are then deposited in the newly created Peer Support Professional Workforce Cash Fund. DHS may seek, accept, and expend gifts, grants, or donations to be deposited in the cash fund. The General Assembly may appropriate funds into the cash fund. All interest and income from the deposit and investment of money in the cash fund is credited to the fund. Any unexpended and unencumbered money in the fund at the end of the fiscal year remains there and cannot be transferred to the General Fund or any other fund.

Medicaid Billing & Reimbursement

Subject to available appropriations and federal law, Medicaid is to include peer support professional services provided through a recovery organization are to be covered. These services must not be provided to enrollees until federal approval is obtained.

Contracts with Managed Service Organizations

Contracts between OBH and MSOs must include terms that outline expectations for the MSO to invest in the state's recovery services infrastructure, including peer-run recovery support services and specialized services for underserved populations. Investments are based on available appropriations.

Addition of 'Recovery' Language

Updates the behavioral health entity implementation and advisory committee to add recovery services to "one member that represents a provider of substance use disorder treatment and recovery services that is not a community health center."

The bill adds recovery services for pregnant and parenting women that are eligible for DHS' program for residential SUD treatment.

The bill adds recovery services to the Native American substance abuse treatment cash fund.

The bill adds recovery services to the list of specialized service needs that are considered in rate-setting for child welfare services.

The bill adds recovery services to the definition of an engaged client in regards to the care navigation program.

The bill adds recovery services to the grant with the purpose of the building substance use disorder treatment capacity in underserved communities. It currently has the goal of increasing access to a continuum of substance use disorder treatment services.

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

Reasons to Support

The bill allows for recovery organizations to be reimbursed, expanding the peer workforce to support individuals in substance use recovery and/or those with a mental health disorder. In addition, the bill requires the recovery organizations to have a process to interact with other community behavioral health organizations, which could improve care coordination throughout the continuum. Further, current Medicaid policy limits the scope of peer-delivered services in Colorado; the bill would allow for peer workers to practice in other settings, such as criminal justice, and be eligible for Medicaid reimbursement.

By adding the term “recovery” in a variety of behavioral health sections of statute will ensure that recovery services are recognized as a part of the treatment continuum for SUDs.

Supporters

- Boulder County
- Children’s Hospital Colorado
- Colorado Children’s Campaign
- Colorado Coalition for the Homeless
- Colorado Community Health Alliance
- Colorado Cross-Disability Coalition
- Colorado Hospital Association
- Colorado Municipal League
- Colorado Psychiatric Society
- Denver Health
- Illuminate Colorado
- Mental Health Colorado
- Rocky Mountain Crisis Partners

Reasons to Oppose

This expansion of where peer workers can work to be reimbursed by Medicaid could increase the state financial obligation under Medicaid. Similarly, by including recovery services in statutory language for existing programs could increase the need for further state funding for those programs. In addition, by including requirements around recovery services in state contracts with MSO’s could require the diversion of funds from current local priorities to recovery services.

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.

Health District
OF NORTHERN LARIMER COUNTY

3/5/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB21-1054: HOUSING PUBLIC BENEFIT VERIFICATION REQUIREMENT

Concerning a housing assistance exception to the requirement to verify lawful presence in the United States for public benefit.

Details

Bill Sponsors:	House – Jackson (D) Senate – Gonzales (D)
Committee:	House State, Civic, Military, and Veterans Affairs
Bill History:	2/16/2021- Introduced in House 2/25/2021- House State, Civic, Military, and Veterans Affairs Committee Refer Amended to House Committee of the Whole 3/2/2021- Passed House Second Reading 3/3/2021- Passed House Third Reading
Next Action:	Introduction in Senate
Fiscal Note:	2/19/2021

Bill Summary

Currently, both federal and state law require that individuals verify lawful presence to receive certain government benefits. This bill removes the requirement to verify lawful presence for public or assisted housing benefits.

Issue Summary

Federal Law: State & Local Public Benefits

Federal law has a variety of restrictions on benefits for undocumented immigrants. This section will focus on restrictions for state and local public benefits. Federal law states that undocumented immigrants are not eligible for any state or local public benefit[1], except in certain circumstances.[2] The exceptions include:

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

[1] 8 U.S. Code § 1621

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

[3] 42 U.S. Code § 1396b(v)(3)

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

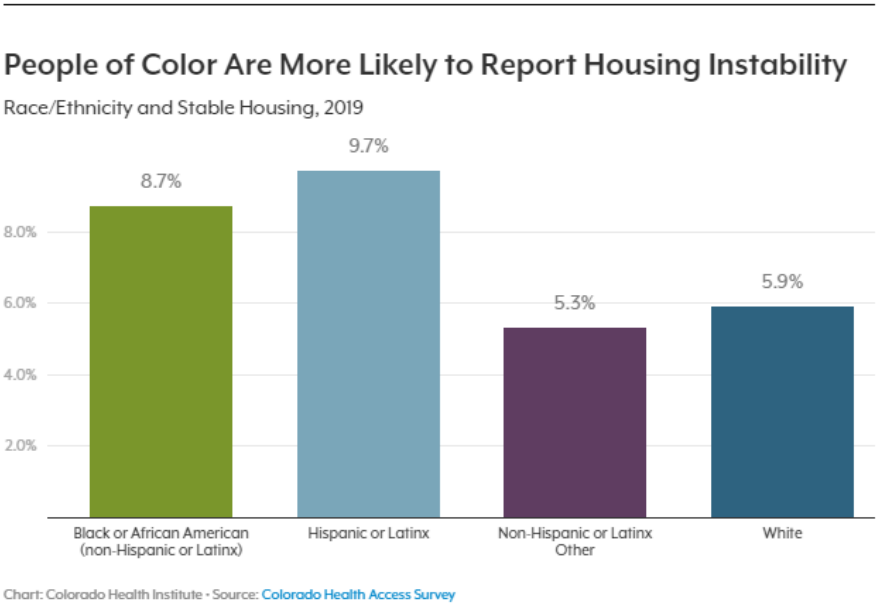
State Law: Restriction of Public Benefits

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

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

Housing

Colorado has a shortage of rental homes that are affordable and available to those households with extremely low incomes.[5] There are approximately 165,000 extremely low income renter households in Colorado but a shortage of 114,000 rental homes that are affordable and available for those renters. [6] Because of the shortage, nearly 75% of extremely low income renter households have a severe cost burden.



Even before the onset of the COVID-19 pandemic, Coloradans were experiencing housing instability. In 2019, 6.7% of Coloradans (360,000) were worried that they would not have a stable place to live in the next two months.[7] More than half of those that reported this worry also reported problems paying for food and medical bills. Additionally, nearly half of those reporting housing instability reported their health

[4] Same definition as the federal law

[5] Extremely low incomes are defined as those at or below the federal poverty level (FPL) or 30% of their area median income (AMI). National Low Income Housing Coalition (n.d) *Colorado.* Retrieved from https://nlihc.org/housing-needs-by-state/colorado

[6] National Low Income Housing Coalition (n.d) *Colorado.* Retrieved from https://nlihc.org/housing-needs-by-state/colorado

[7] Colorado Health Institute (June 9, 2020). *Making a Home for Health: Supporting Health by Putting Housing First.* Retrieved from https://www.coloradohealthinstitute.org/research/making-home-health

being fair or poor (44.1%), their oral health being poor or fair (46.8%), and having poor mental health (45.8%). People of color were more likely to report housing instability than white Coloradans. Further, 14.4% of Coloradans who are not U.S. citizens reported instability, which is more than double that of citizens (6.5%).

Colorado has about 10,857 people experiencing homeless on a given night.[8] Larimer County's temporary COVID-19 shelter, day shelter, and inclement weather shelters, operated by Homeward Alliance and Fort Collins Rescue Mission, serve up to 200 people daily. More households than ever before are on the brink of housing instability in Larimer County. This is reflected in the increased number of people per week currently seeking services through Murphy Center for Hope program. The Murphy Center is a collaboration between 20 independent organizations that serves as a hub of services for people who face homelessness or housing instability. Between October 1, 2020, and December 31, 2020, the Murphy Center served 1,124 unduplicated people, averaging 125 check-ins per day. Just under 50% of the people served identified themselves as living with a disability and 35% of the people served were ages 50 or older. The Murphy Center has recorded an increase of roughly 30 new entries to homelessness each week.

This Legislation

The bill adds to the list of exceptions for verification of lawful presence the receipt of public or assisted housing, housing services, housing assistance, or other similar benefit, unless required by federal law.

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

Fiscal Note

The fiscal note finds that starting in fiscal year 2021-22, the bill will decrease state workload on an ongoing basis. Therefore, no appropriation is required.

Reasons to Support

Housing is associated with improved health. Ensuring all Coloradans, regardless of immigration status, are eligible to apply for and receive housing assistance and participating in housing programs will aid in improving health status and assuring family stability. Renters that are cost burdened are more likely than others to sacrifice other necessities like food, utilities, and health care to pay for rent. For example, with such an exemption the Division of Housing within the Department of Local Affairs would be able to finance agriculture housing for transient farm workers and provide direct rental assistance with state funds during the COVID-19 pandemic to those without documentation.

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

Supporters

- American Civil Liberties Union of Colorado
- Boulder County
- Colorado Center on Law & Policy
- Colorado Children's Campaign
- Colorado Coalition of the Homeless
- Colorado Cross-Disability Coalition
- Colorado Mountain College
- Colorado Nonprofit Association
- Counties & Commissioners Acting Together (CCAT)
- COVID-19 Eviction Defense Project
- Enterprise Community Partners
- Interfaith Alliance

[8] National Alliance to End Homelessness (2019) *Colorado.* Retrieved from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/colorado/

- Mental Health Colorado
- Stand for Children
- Together CO
- United for a New Economy
- Violence Free Colorado

Reasons to Oppose

Some may assert that due to their documentation status, individuals should not be allowed to access publicly-funded services. Including this exception in statute could increase demand on these programs, necessitating future funding by both state and local governments.

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.

POLICY

March 9, 2021

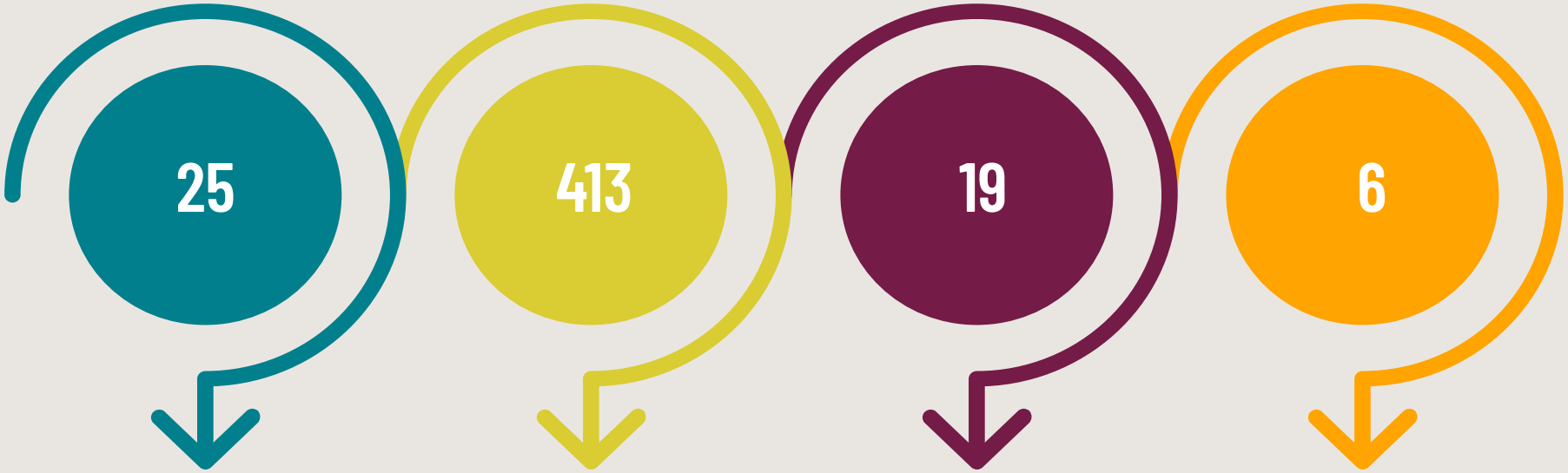
TOPICS OF DISCUSSION

01 INTRODUCE IDA!!

02 STATE

03 FEDERAL

STATE


25
DAYS IN SESSION
413
BILLS INTRODUCED
19
BILLS KILLED/LOST
6
ISSUES WITH A POSITION

HB21-1021: PEER SUPPORT PROFESSIONALS BEHAVIORAL HEALTH

HOUSE: Pelton (R) & Caraveo (D)
SENATE: None

3/9 Hearing
House State, Civic, Military & Veterans Affairs

The bill requires DHS to develop a procedure to approve recovery support services organizations that meet certain qualifications, including those established by rule by DHS in collaboration with the HCPF. The bill specifies that peer support professional services provided through an approved recovery support services organization can to be covered under Medicaid.

Other Considerations- Fiscal Note:

- Fee amount- need to be subsidized by General Fund?

2 Amendments
Passed unanimously out of committee at 2:30pm

HB21-1054: HOUSING PUBLIC BENEFIT VERIFICATION REQUIREMENT

HOUSE: Jackson (D)
SENATE: Gonzales (D)

March 23 Hearing
Senate State, Veterans & Military Affairs

Currently, both federal and state law require that individuals verify lawful presence to receive certain government benefits. This bill removes the requirement to verify lawful presence for public or assisted housing benefits.

SB21-011: PHARMACIST PRESCRIBE DISPENSE OPIATE ANTAGONIST

SENATE: Fields (D)
HOUSE: Mullica (D) & Pelton (R)

March 10 Hearing
Senate Health & Human Services

The bill requires a pharmacist who dispenses an opioid prescription to inform the patient of the potential dangers of an opioid and to offer to prescribe the patient an opiate antagonist in the following circumstances:

- If, in their professional judgement, the patient would benefit
- The patient has a history of opioid overdose or substance use disorder (SUD)
- At the same time, the patient is also prescribed a benzodiazepine, a sedative hypnotic drug, carisoprodol, tramadol, or gabapentin OR
- The prescription is a 90 morphine milligram equivalents (MME) or more

SB21-016: PROTECTING PREVENTIVE HEALTH CARE COVERAGE

SENATE: Pettersen (D) & Moreno (D)
HOUSE: Esgar (D) & Mullica (D)

March 16 Hearing
Senate Health & Human Services

The bill would codify into Colorado state law several preventive health care services provided under the federal "Patient Protection and Affordable Care Act" (ACA). Such codification would require Colorado health insurance carriers to provide these services without policy deductibles, copayments, or coinsurance.

- The bill requires preventive services to be expanded beyond the current ACA list of preventive services recommended by USPSTF, HRSA, and NAM to include osteoporosis screenings for men, urinary incontinence screenings for men, and expanded coverage for the counseling, prevention, screening, and treatment of any STI.

SB21-085: ACTUARIAL REVIEW HEALTH INSURANCE MANDATE LEGISLATION

SENATE: Ginal (D) & Smallwood (R)
HOUSE: Lontine (D)

TBD Hearing
Senate Finance

By November 1, 2021, the Division of Insurance (DOI) is to retain a contractor that has experience with health care policy and actuarial reviews. The contractor is to perform actuarial reviews on proposed legislation that may impose a new health benefit mandate on health plans.

SB21-085

PROS

- Can inform future changes to mandated benefits
- Can support claims by advocates

SB21-085

CONS

- Medicaid/CHP+ are public programs that have unique frameworks/functions (i.e. federal match, varying state options, populations served, etc.)
- Only addresses new benefits added
- Health equity issues not addressed
- The amount of time considered is short
- Focus on cost rather than balance of cost & cost savings
- Length of time needed for such a review could make it impossible for such a bill to move in a single legislative session

SB21-085

PROPOSED AMENDMENTS- Public Programs

1. Legislators should not be able to request an actuarial review of legislation that focuses on expanding benefits in public health insurance
2. Strike Section VI
    a. (VI) AN ESTIMATE OF THE INCREASE IN EXPENDITURES, IF ANY, FOR MEDICAL ASSISTANCE PROVIDED PURSUANT TO THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5, THAT WOULD RESULT FROM THE PROPOSED LEGISLATION, REGARDLESS OF 5 WHETHER THE PROPOSED LEGISLATION AMENDS THAT ACT;

SB21-085

PROPOSED AMENDMENTS- Benefits Added/Removed/Cut

1. The bill should allow for legislators to request actuarial analyses any time an insurance benefit is cut or reduced, in addition to being able to request analyses of new benefits.

SB21-085

PROPOSED AMENDMENTS- Health Equity

1. The actuarial review completed under this bill should allow legislators to understand who would benefit from the proposal.
2. required report should also include an equity analysis informed by a contractor who is qualified to examine historical context and current injustices, describe who would benefit and who would be burdened by the proposed policy change, and describe which inequities would be improved through the bill and which would be perpetuated.
3. The contracted actuary should be selected through a process that includes consumer stakeholders.
4. A new section should be added:
    a. (X) IDENTIFICATION OF WHO WOULD BENEFIT FROM THE PROPOSED LEGISLATION, INCLUDING AT A MINIMUM THEIR
        i. 1. RACE AND ETHNICITY
        ii. 2. SEX
        iii. 3. GENDER
        iv. 4. INCOME
        v. 5. AGE
        vi. 6. ABILITY

SB21-085

PROPOSED AMENDMENTS- Potential Savings & Time Period

1. Sections IV (premiums), V (cost of coverage state employee plan), VI (public programs), and VII (cost of coverage for different sized employers) should include required reporting of any potential costs or savings.
2. Section VII should be broken out into much more detail. It should include savings on premiums and cost sharing, the number of total out-of-pocket dollars per year saved by impacted individuals, and the near and long-term cost savings to entitlement programs including Medicaid, CHIP, TANF, SNAP, and WIC.
3. Increases in productivity, such as those created through improvements to rehabilitative benefits, should also be included.
4. Sections VIII and IX should be amended as follows:
    a. (VIII) AN ESTIMATE OF THE POTENTIAL LONG-TERM COST SAVINGS ASSOCIATED WITH ANY NEW HEALTH BENEFIT OR SERVICE DESCRIBED IN THE PROPOSED LEGISLATION OVER AT LEAST A 10-YEAR WINDOW; AND
    b. (IX) IDENTIFICATION OF ANY POTENTIAL HEALTH BENEFITS THAT WOULD RESULT FROM ANY NEW HEALTH BENEFIT OR SERVICE DESCRIBED IN THE PROPOSED LEGISLATION OVER AT LEAST A FIVE AND 10-YEAR WINDOW.

SB21-085

PROPOSED AMENDMENTS- Time Intensiveness

1. Any coverage mandate that results in a premium impact of less than 1% should be deemed negligible and the contractor should not perform further estimates that are outlined in the bill.
2. The length of time required for the actuarial analysis should not prohibit a bill from moving in a single legislative session. This may require flagged bills to be identified before session begins.

SB21-175: PRESCRIPTION DRUG AFFORDABILITY REVIEW BOARD

SENATE: Jaquez Lewis (D) & Gonzales (D)
HOUSE: Caraveo (D) & Kennedy (D)

TBD Hearing
Senate Health & Human Services

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

SB21-175

CO Prescription Drug Affordability Review Board (PDAB)-Establishment

- 5 Members- Governor Appointed by Oct 1, 2021
- Term of Office: 3 Years
- Conflict of interests must be disclosed and must recuse themselves from any activity that has a conflict of interest and must be posted on DOI public website
- Board member cannot be a employee/board member/consultant of:
  - Manufacturer or its trade association
  - Carrier or its trade association
  - PBM or its trade association
- The Board can hire staff & the AG is to appoint an Asst. AG to provide legal counsel

SB21-175

CO Prescription Drug Affordability Review Board (PDAB)-Duties/Powers

- Duties
  - Collect & evaluate information concerning the cost of prescription drugs sold to Colorado consumers
  - Perform affordability reviews
  - Establish upper payment limits
  - Make policy recommendations to the General Assembly to improve affordability
- Powers
  - Can establish ad hoc work groups
  - Enter into contract with third-party contractors
- Can promulgate rules necessary
- Can seek, accept, and expend gifts, grants, and donations

SB21-175

CO Prescription Drug Affordability Review Board (PDAB)-Meetings

- First meeting within 6 weeks of all appointments
- Meet at least every 6 weeks after- chair can cancel or postpone a meeting if the board has no drugs to review
- All meetings are public and fall under open meetings law
- Can meet in executive session to discuss proprietary information

SB21-175

Required reports from carriers & PBMs

- Starting 2022 for all dispensed drugs paid for by a health plan the following is to be reported by each carrier:
  - Top 15 drugs by volume
  - 15 costliest, by total annual plan spending
  - 15 drugs that account for highest increase in annual plan spending
  - 15 drugs caused greatest increases in premiums
  - 15 drugs the carrier paid most frequently & received a rebate
  - 15 drugs the carrier reviewed the highest rebates (by %)
  - 15 drugs the carrier received the largest rebates
- Carriers & Carriers' PBMs report the average WAC for each category:
  - Brand-name purchased from retail pharmacies
  - Generics from retail pharmacies
  - Brand-name from mail-order pharmacies
  - Generics from mail-order pharmacies
  - Physician administered drugs (inpatient & outpatient)
- Carriers & Carriers' PBMs average WAC for the above categories paid by category- individual, small employer, large employer

SB21-175

Required reports from carriers & PBMs (cont.)

- Information to be posted on DOI website & provided to PDAB
- If carrier or PBM claims information to be confidential/proprietary- DOI review information and redact specific items for public review
- The reporting requirement does not prohibit a manufacturer from making pricing decisions or prohibit purchasers from negotiating discounts/rebates consistent with existing law

SB21-175

Affordability Reviews

- When determining to conduct a review- PDAB to identify drug that:
  - Brand-name or biologic that has an initial WAC $30,000+ for 12 month course or a treatment less than 12 months OR an increase of the WAC of $3,000+ during immediately preceding 12 months
  - Biosimilar drug that is not at least 1% lower than its corresponding biologic
  - Generic drug that has a WAC $100+ for a 30 day supply (based on FDA approval), a supply less than 30 days, 1 dose if the FDA does not recommend a finite dosage AND WAC increase by 200%+ during the preceding 12 months
- After identifying those drugs- PDAB determine whether to conduct a review by:
  - Evaluating class & whether any therapeutically equivalent drugs available
  - Evaluating aggregated data
  - Seeking/considering input from advisory council
  - Considering average patient's OOP cost

SB21-175

Affordability Reviews (cont)

- If the PDAB conducts a review- it must determine whether the use of the drug consistent with FDA approved labeling or standard medical practice is unaffordable for CO consumers
- PDAB consider:
  - WAC
  - Cost & availability of therapeutic alternatives
  - Effect of the price on consumer access
  - Relative financial effects on health, medical, social services costs
  - Patient copayment/cost sharing associated with the drug typically required by plans
  - Other info that the manufacturer/carrier/PBM chooses to provide
  - Other factors as determined by PDAB rules

SB21-175

Upper Payment Limits

- PDAB can set a UPL for any drug that underwent an affordability review & was determined to be unaffordable for CO consumers
- By rule, PDAB determine methodology to set UPL must include consideration of:
  - Cost of administering/dispensing drug
  - Cost of distribution within the state
  - Other relevant costs related to the drug
- UPL applies to ALL purchases or and reimbursements for a drug that is dispensed/administered in the state
- An entity providing/administering a self-funded plan can elect to be subject to be subject to the PDAB

SB21-175

PDAB Advisory Council

- 14 members
  - HCPF ED
  - 2 consumers or who represent consumers
  - 1 statewide health advocacy organization
  - 1 representing consumers living with chronic diseases
  - 1 representing labor union
  - 1 representing employers
  - 1 representing carriers
  - 1 representing PBMs
  - 1 representing health care professionals
  - 1 employed by organization that researches prescription drugs
  - 1 representing brand-name manufacturer
  - 1 representing generic manufacturer
  - 1 representing pharmacists
- Appointed by Jan 1, 2022
- Three year terms
- Meet at least once every 3 months- chair may cancel/postpone

SB21-175

Use of Savings

- Any savings from setting UPL must be used by carrier to reduce consumer costs
- By March 15, 2023, and each March 15 after- each state entity and each carrier that issues a plan or an optional participating plan shall report to the PDAB describing savings and how those savings were used

SB21-175

Enforcement

- After Jan 1, 2022 it is unlawfufl for any person to purchase or reimburse a payer for a drug with a UPL, in an amount in excess of that UPL
  - May be subject to fine of $1000 per violation
- AG can enforce this bill on behalf of any state entity or consumer of prescription drugs
- If manufacturer intends to withdraw from sale/distribution in CO for a drug with a UPL has to provide notice at least 180 days in advance- DOI may require them to pay a penalty not to exceed $150,000 if proper notice is not given

HB21-XXXX: PUBLIC OPTION

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

Introduction Later this Week

(2) EACH HEALTH-CARE PROVIDER SHALL ACCEPT CONSUMERS WHO ARE ENROLLED IN ANY HEALTH BENEFIT PLAN OFFERED BY THE AUTHORITY.

FEDERAL

COVID Legislation- Health Related

Premium Tax Credits
No marketplace enrollee spends more than 8.5% of income on premiums
Extend to those >400%FPL

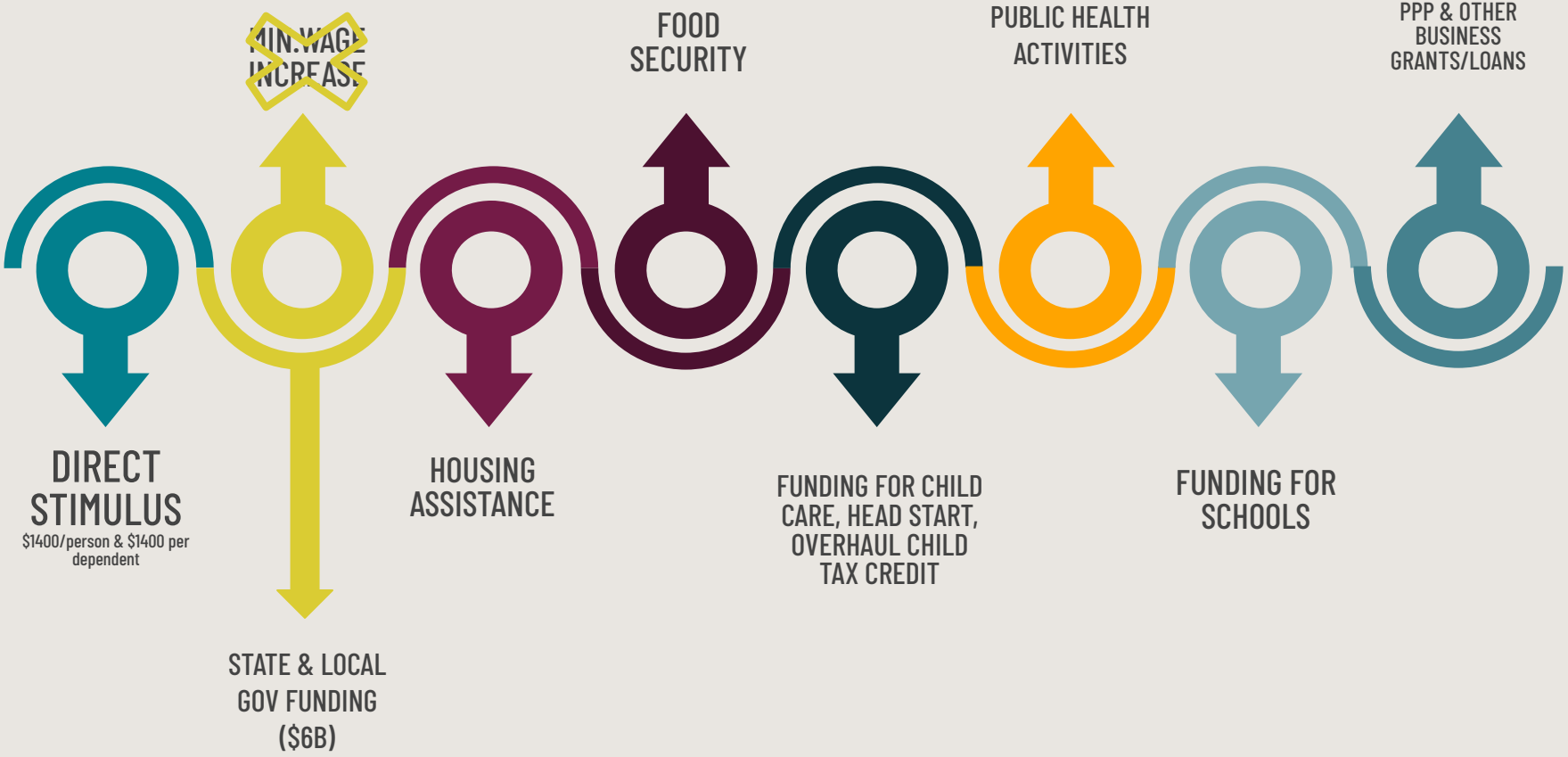
$0 Premiums
People with income below 150% of the FPL
If getting UI & qualified to purchase on marketplace, can get $0 premium on silver plan (are some stipulations)

COBRA Subsidies
Federal funding to cover ~~85% of~~ COBRA premiums from month after enactment to September 30,2021

now 100%

Medicaid Expansion
2-year increase in FMAP when a state expands

COVID Legislation- What Else?



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Health District
OF NORTHERN LARIMER COUNTY

3/5/2021

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

SB21-011: PHARMACIST PRESCRIBE DISPENSE OPIATE ANTAGONIST

Concerning responsibilities of a pharmacist related to opiate antagonists, and, in connection therewith, authorizing a pharmacist to prescribe an opiate antagonist and requiring a pharmacist who dispenses an opioid to offer to prescribe or dispense an opiate antagonist in certain situations.

Details

Bill Sponsors:	Senate – *Fields (D),* Priola (R) House – *Mullica (D) and Pelton (R)*
Committee:	Senate Health & Human Services
Bill History:	2/16/2021- Introduced in Senate
Next Action:	3/10/2021- Hearing in Senate Health & Human Services Committee

Bill Summary

The bill requires a pharmacist who dispenses an opioid prescription to inform the patient of the potential dangers of an opioid and to offer to prescribe the patient an opiate antagonist in the following circumstances:

- If, in their professional judgement, the patient would benefit
- The patient has a history of opioid overdose or substance use disorder (SUD)
- At the same time, the patient is also prescribed a benzodiazepine, a sedative hypnotic drug, carisoprodol, tramadol, or gabapentin
- The prescription is a 90 morphine milligram equivalents (MME)[1] or more

Issue Summary

Prescribing of Opioids

Nationally, the opioid prescribing rate has decreased to 46.7 prescriptions per 100 people in 2019 from 81.3 opioid prescriptions per 100 persons in 2012.[2] In 2018, the opioid prescribing rate in Colorado was 45.1 per 100 people, which has decreased from 73.5 prescriptions per 100 people in 2012.[3] 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 62.2 prescriptions per 100 people in 2016.[4]

[1] Morphine Milligram Equivalents is a value that is assigned to opioids to represent their relative potency to provide for the ease of comparison.
[2] Centers for Disease Control and Prevention. (July 31, 2017). *U.S. Prescribing Rate Maps.* Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html
[3] National Institute on Drug Abuse (2020). *Opioid Summaries by State.* Retrieved from https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state
[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] 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.

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.[7] Additionally the department limited dosages of opioids to a certain threshold (200 MME per day) for pain management and anything above that MME requires prior authorization.

In 2017, the Colorado Chapter of the American College of Emergency Physicians (COACEP) promulgated practice and policy recommendations regarding opioids.[5] One of the practice recommendations is the frequent consultation of the PDMP by emergency department (ED) physicians. The recommendations also suggest prescribing the lowest effective dose in the shortest appropriate duration and refusing to refill lost or stolen opioid prescriptions.

Opiate Antagonists

Naloxone is a commonly used opiate antagonist utilized to reverse an opioid overdose in order to save a person's life. There are four methods to administer the drug: intramuscular, auto-injectable, intravenous, and nasal spray. The intramuscular, auto-injectable, and nasal spray can be used by the lay public. Paramedics utilize intravenous naloxone. As of 2017, more than 500 Colorado pharmacies stock and 140 law enforcement departments carry naloxone.[8,9] Under the statewide opioid grants[10] that began in May 2017, 57,407 naloxone kits have been distributed and 3,097 overdose reversals have been reported.[11]

Overdose

In 2019, the rate of drug overdose deaths in Larimer County was 14 per 100,000.[12] In Larimer County, a group of community partners are working to expand the availability of naloxone to save lives. A project of the Mental Health and Substance Use Alliance of Larimer County (managed by the Health District of Northern Larimer County's Community Impact Team) and the Northern Colorado Collaborative for Addiction and Recovery Support (NOCO-CAReS) aims to unify, support, and increase local efforts to make naloxone available to those in Larimer and Weld Counties who may be in a position to reverse an opioid overdose. The project began with an initial scan of naloxone distribution and educational activities in the community as related to the Colorado Consortium for Prescription Drug Abuse Preventions' Naloxone Work Group's sector-specific goals. The local Naloxone Champions group is currently providing naloxone and training to Health

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[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] 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

[8] Colorado Office of Behavioral Health (OBH), prepared by Colorado Health Institute (CHI) (July 28, 2018). *Needs Assessment for the SAMHSA State Targeted Response to the Opioid Crisis Grant.* Retrieved from https://coag.gov/sites/default/files/contentuploads/oce/Substance_Abuse_SA/SATF-reports/11th_annual_substance_abuse_task_force_report_2016_final_2.pdf

[9] Colorado Consortium for Prescription Drug Abuse Prevention (n.d.) *Naloxone.* Retrieved from https://corxconsortium.org/naloxone/#:~:text=As%20of%202017%2C%20more%20than%20500%20pharmacies%20in%20Colorado%20carry%20naloxone.

[10] In May 2017, OBH received $15.7 million over two years from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the State Targeted Response (STR) Grant. This grant ended in April 2019. In September 2018, OBH received $38 million over two years for the State Opioid Response (SOR) Grant from SAMHSA. In August 2020, OBH was awarded $41.6 million until September 2022.

[11] OBH (Dec. 3, 2020). *State Targeted Response to the Opioid Crisis.* Retrieved from https://drive.google.com/file/d/1ZQ0EbBf88rs65qObSRhgIC61PhEwYhxp/view

[12] CDPHE (2020). *Colorado Drug Overdose Dashboard.* Retrieved from https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/DrugOverdoseDashboard/LandingPage?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link

and Human Service agencies and the general public and has provided over 40 organizations trainings to date. From 2018 to the end of 2019, over 4,000 overdose prevention kits (includes two doses of naloxone) were distributed with training in Larimer and Weld Counties through the Naloxone Champions Work Group Partners. This group also plans the annual Overdose Awareness Day events in Northern Colorado.

Interaction of Opioids and Other Prescription Medications

More than 30 percent of overdoses involving opioids also involve benzodiazepines, a type of prescription commonly prescribed for anxiety or to help with insomnia.[13] Common benzodiazepines include Valium, Xanax, and Klonopin. The 2016 CDC opioid prescribing guidelines included a recommendation that providers avoid prescribing benzodiazepines and opioids concurrently whenever possible.[21] A study in North Carolina found that the overdose death rate in patients that had both medications was 10 times higher than those that only received opioids.[14] In 2017, 9.7 percent of patient prescription days in Colorado had overlapping opioid and benzodiazepine prescription use.[15]

Carisoprodol is a muscle relaxant that is broken down in the liver which can bind to receptors that enhance the effects of benzodiazepines.[16] Carisoprodol alone or with other agents (opioids and benzodiazepines, in particular) reportedly caused more than 30,000 emergency department visits in 2009.[17]

Gabapentin is used with other medications to prevent and control seizures as well nerve pain from shingles.[18] Both opioids and gabapentin can suppress breathing, and gabapentin may also increase the absorption of opioids. A study from the University of Toronto found that the combination of the two drugs is potentially deadly, as the concurrent use of the drugs was associated with a 49% higher risk of dying from an opioid overdose compared to opioid use alone.[19]

Past Legislation: HB20-1065

The bill required a pharmacist, who dispenses an opioid prescription, is to notify the patient about the availability of naloxone at no charge when, in the pharmacist's professional judgement, the patient would benefit from the notification.

This Legislation

Currently, a pharmacist dispensing an opioid prescription is to notify a patient about the availability of naloxone when, in the pharmacist's professional judgement, the patient would benefit from the notification. The bill strikes that language and replaces it with the following. The bill requires a pharmacist dispensing an opioid to inform the patient of the potential dangers of a high dose and to offer to prescribe or dispense to the patient an opiate antagonist if:

- In the pharmacist's professional judgment, the patient would benefit from the information
- The patient has a history of prior opioid overdose or substance use disorder
- At the same time the patient is prescribed a benzodiazepine, a sedative hypnotic drug, carisoprodol, tramadol, or gabapentin or
- The prescription is 90 MMEs or more

[13] National Institute on Drug Abuse (NIDA) (March 2018). *Benzodiazepines and Opioids.* Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

[14] Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality. *Pain Med Malden Mass*. 2016;17(1):85-98. doi:10.1111/pme.12907.

[15] Colorado Consortium for Prescription Drug Abuse Prevention (n.d.) *Consortium Dashboard.* Retrieved from https://public.tableau.com/profile/omni#!/vizhome/RXConsortiumdashboard/Readmefirst

[16] Fudin, J. (Sept. 2014). *The Perfect Storm: Opioid Risks and 'The Holy Trinity.'* Retrieved from https://www.pharmacytimes.com/contributor/jeffrey-fudin/2014/09/the-perfect-storm-opioid-risks-and-the-holy-trinity

[17] RxInformer (Fall 2013). *Deadly Drug Combinations Escaping Notice.* Retrieved from https://rxinformer.healthesystems.com/article.php?id=52

[18] MedlinePlus (2020). *Gabapentin.* Retrieved from https://medlineplus.gov/druginfo/meds/a694007.html

[19] Gomes, T. et al. (Oct. 2017). Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-sontrol study. *PLOS Medicine.* https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002396

If the patient accepts the pharmacist's prescription for an opiate antagonist, they should counsel the patient on how to use it in an event of an overdose. The requirement to notify a patient about the availability of an opiate antagonist does not apply to a patient who has a cancer diagnosis, who is in sickle cell crisis, or who is in hospice or palliative care.

The bill allows a pharmacist to prescribe an opiate antagonist. Currently, pharmacists may only dispense in accordance with standing orders and protocols.

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

Reasons to Support

By requiring a pharmacist dispensing an opioid to always inform the patient of the potential dangers of a high dose, the bill assists in educating patients in the risks associated with the medication. Such consistent and widespread patient education could aid in decreasing the frequency of opioid overdoses and of opioid overdose deaths. By requiring pharmacists to offer the patient a supply of opiate antagonists, the bill provides the opioid patient population with a medical tool for well-being in the case of an overdose. In addition, many patients may not know that the prescribed opioid and another prescribed drug may negatively interact. Thus, this bill would assist in more patients across Colorado to protect themselves in the case of an opioid overdose. Increasing the public availability to opiate antagonists should help to decrease the frequencies of opioid overdose deaths. For some, pharmacists are more publicly accessible than doctors. Using pharmacies as the patient source of opiate antagonists helps to increase its supply throughout the opioid-consuming patient population.

Supporters

- Colorado Behavioral Healthcare Council
- Colorado Psychiatric Society
- Emergent Biosolutions
- National Alliance on Mental Illness- Colorado

Reasons to Oppose

This bill would likely require pharmacies to purchase and sustain a significant supply of opiate antagonists. It is unknown if the cost be placed onto the patient, insurance, the pharmacies, or the state. The bill may disrupt pharmacies' larger patient-service goals, which could translate into longer wait-times for all patients and limited physical storage capacities. Also, it appears that pharmacy technicians would not be able to provide patients with opiate antagonists, which may unduly stretch the capacities of the few pharmacists at each pharmacy. Separately, a "pharmacist's professional judgment" is very subjective and not likely to result in equal opiate antagonist distribution across all pharmacists of Colorado.

Opponents

- Colorado Pharmacists Society
- Colorado Retail Council
- CVS Health

Other Considerations

Patient privacy considerations should be clarified: Do pharmacies already know of their patient's substance use disorder, cancer, or sickle cell diagnoses, or would patients be required to disclose that information? How would the pharmacist ensure the privacy of such conversations regarding these diagnoses? Would access to private rooms be required to preserve patient confidentiality?

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

03/5/2021

STAFF: IDA COSSITT-GLESNER
& ALYSON WILLIAMS

POLICY ANALYSIS

SB21-016: PROTECTING PREVENTIVE HEALTH CARE COVERAGE

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.

Details

Bill Sponsors:	House – Esgar (D) and Mullica (D) Senate – Pettersen (D) and Moreno (D)
Committee:	Senate Health & Human Services
Bill History:	2/16/2021- Introduced in Senate
Next Action:	3/16/2021- Hearing in Senate Health & Human Services

Bill Summary

The bill would codify into Colorado state law several preventive health care services provided under the federal "Patient Protection and Affordable Care Act" (ACA). Such codification would require Colorado health insurance carriers to provide these services without policy deductibles, copayments, or coinsurance. The bill expands preventive health services to include screenings for osteoporosis and urinary incontinence, as well as for the counseling, prevention, screening, and treatment of a sexually transmitted infection (STI). The bill additionally authorizes reimbursement for family planning services and family-planning-related services provided by any licensed health care provider.

Issue Summary

Affordable Care Act

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 Supreme Court will decide whether to strike down the ACA as unconstitutional, as the previous Trump Administration and 18 Republican state attorneys general urged.[4] At the center of the attorneys' general argument is that the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* upheld under Congress' taxing power the ACA's requirement that individuals have coverage or pay a penalty, and the 2017 tax law zeroed out that penalty. Without the tax, they claim, the coverage requirement is unconstitutional, making the rest of the ACA also unlawful. If the ACA is declared unconstitutional by the Supreme Court, the four pillars of protections would also fall. If states have not

[1] KFF, Summary of the Affordable Care Act, Apr 25, 2013. https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/
[2] HealthCare.gov, Preventive Health Services. https://www.healthcare.gov/coverage/preventive-care-benefits/
[3] KFF, Preventive Services Covered by Private Health Plans under the Affordable Care Act. https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/
[4] Center on Budget and Policy Priorities (2021). *Suit Challenging ACA Legally Suspect But Threatens Loss of Coverage for Tens of Millions*. Retrieved from https://www.cbpp.org/research/health/suit-challenging-aca-legally-suspect-but-threatens-loss-of-coverage-for-tens-of

codified these protections, it is possible that state-regulated insurance carriers in those states would opt to not provide the same coverage as under the ACA requirements.

Preventive Services Covered Under the ACA

The following are the preventive care benefits for adults[5]:

- Abdominal aortic aneurysm one-time screening for men of certain ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screenings for adults 50-75
- Depression screenings
- Diabetes (Type 2) screening for adults 40-70 who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65+, living in a community setting
- Hepatitis B & C screening for adults at high risk
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- Immunization vaccines for adults[6]
- Lung cancer screening for adults 55-80 at high risk
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Statin prevention medication for adults 40-75 at high risk
- Syphilis screening for adults at high risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening

The following are the preventive care benefits for women [7]

- Anemia screening on a routine basis, for pregnant women or women who may become pregnant
- Breast cancer mammography screenings every 1 to 2 years for women over 40 and genetic testing for those at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies
- Cervical cancer screening
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk
- Gonorrhea screening for all women at higher risk
- Osteoporosis screening for women over age 60 depending on risk factors
- Preeclampsia prevention and screening
- Rh incompatibility screening for all pregnant women and follow-up testing for those at higher risk
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening
- Urinary incontinence screening for women yearly
- Well-woman visits to get recommended services for women under 65

[5] HealthCare.gov, Preventive Care Benefits for Adults. https://www.healthcare.gov/preventive-care-adults/

[6] Doses, recommended ages, and recommended populations vary

[7] HealthCare.gov, "Preventive Care Benefits for Women". https://www.healthcare.gov/preventive-care-women/

In addition to the select benefits listed above there are also benefits outlined for pregnant women or women who may become pregnant and for children.[4,8]

Identifying and Categorizing Preventive Services

The ACA requires plans to cover the services listed in the U.S. Department of Health and Human Services' (HHS) comprehensive list of preventive services.[9] Such required preventive services are identified and established through recommendations made by the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration (HRSA), HRSA's Bright Futures Project, the National Academy of Medicine (NAM) committee on women's clinical preventive services, and the U.S. Preventive Services Task Force (USPSTF). [10]

Advisory Committee on Immunization Practices (ACIP). ACIP is a federal advisory committee that was established under Section 222 of the Public Health Service Act[11], as amended.[12] ACIP, composed of medical and public health experts, provides advice and guidance to the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of the Department of Health and Human Services (HHS) regarding the use of vaccines.[13]

Health Resources and Services Administration (HRSA). An agency of HHS, HRSA the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable. Its programs help those in need of high quality primary health care, people with HIV/AIDS, pregnant women, and mothers.[14] *HRSA's Bright Futures Program* aims to improve health outcomes for the nation's infants, children, and adolescents by increasing the quality of primary and preventive care through maintenance and dissemination of age-specific, evidence-driven clinical guidelines.[15]

National Academy of Medicine (NAM). Founded in 1970 as the Institute of Medicine (IOM), the National Academy of Medicine (NAM) is one of three academies that make up the National Academies of Sciences, Engineering, and Medicine. NAM's mission is to improve health for all by advancing science, accelerating health equity, and providing independent, authoritative, and trusted advice nationally and globally.[16] At the request of HHS, NAM convened the *Committee on Women's Clinical Preventive Services* in 2011 to identify critical gaps in preventive services for women, as well as measures to further ensure women's health and well-being. The Committee identified eight preventive services for women be added to the services that health plans will cover at no cost to patients under the ACA.[17] In 2016, HRSA awarded a five-year cooperative agreement to the American College of Obstetricians and Gynecologists (ACOG). ACOG subsequently created the *Women's Preventive Services Initiative*, a coalition of clinician, academic, and consumer-focused health professional organizations, to update recommendations for the Women's Preventive Services Guidelines in accordance with the model created by the NAM Committee on Women's Clinical Preventive Services.[18]

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[8] HealthCare.gov, "Coverage for Children's Preventive Health Services," https://www.healthcare.gov/preventive-care-children/

[9] The National Academies, "IOM Report Recommends Eight Additional Preventive Health Services to Promote Women's Health", July 19, 2011. https://www.nationalacademies.org/news/2011/07/iom-report-recommends-eight-additional-preventive-health-services-to-promote-womens-health

[10] KFF, Preventive Services Covered by Private Health Plans under the Affordable Care Act. https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/

[11] 42 U.S.C. §2l7a

[12] Centers for Disease Control and Prevention, "ACIP Charter", July 14, 2020. https://www.cdc.gov/vaccines/acip/committee/charter.html

[13]Centers for Disease Control and Prevention, "Advisory Committee on Immunization Practices Policies and Procedures", December 2018. https://www.cdc.gov/vaccines/acip/committee/downloads/Policies-Procedures-508.pdf

[14] Health Resources and Services Administration, "About HRSA," October 2019. https://www.hrsa.gov/about/index.html

[15] Health Resources and Services Administration, "Bright Futures", December 2020. https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html

[16] National Academy Of Medicine, "About the National Academy of Medicine", 2021. https://nam.edu/about-the-nam/

[17] The National Academies, "IOM Report Recommends Eight Additional Preventive Health Services to Promote Women's Health", July 19, 2011. https://www.nationalacademies.org/news/2011/07/iom-report-recommends-eight-additional-preventive-health-services-to-promote-womens-health

[18] WPSI, "Overview of the Women's Preventive Services Initiative", 2020. https://www.womenspreventivehealth.org/about/

U.S. Preventive Services Task Force (USPSTF). The USPSTF, administered by the Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention that conducts assessments of scientific evidence of the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. It provides evidence-based recommendations for the use of preventive services, which may vary depending on age, gender, and risk factors for disease, among other considerations. Services are given a grade of "A", "B", "C", "D" or an "I" Statement. Services graded "A" or "B" are recommended. For services graded "C", the USPSTF makes no recommendation for or against their routine use. For services graded "D", the USPSTF recommends against routinely providing the service to asymptomatic patients, based on evidence that the service is not beneficial, and may be harmful. "I" Statements are provided when evidence is insufficient to support a recommendation[19]

Osteoporosis Screening

Since 2018, the USPSTF has recommended screening for osteoporosis in women age 65 years and older, and in women younger than age 65 years who have been through menopause and are at increased risk. This is a "B" recommendation. Thus, the USPSTF expresses a certainty that the net benefit is moderate to substantial. However, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men; this is an "I" statement.[20]

After the age of 50, the prevalence of osteoporosis is greater in women than in men (15.4% vs 4.3%, respectively). The vast majority of studies have been conducted in postmenopausal women exclusively. Only 2 studies were conducted in men. In one of these two studies, the number of fractures in the study was small and the study was stopped early due to concerns over the medication's negative side effects found in animal studies. Thus, the USPSTF found that the evidence is inadequate to assess the effectiveness of drug therapies in reducing subsequent fracture rates in men without previous fractures. Treatments that have been proven effective in women cannot necessarily be presumed to have similar effectiveness in men, and the direct evidence is too limited to draw definitive conclusions. The USPSTF has concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men. However, the USPSTF found convincing evidence that bone measurement tests are accurate for detecting osteoporosis and predicting osteoporotic fractures in both women and men.[21]

Urinary Incontinence Screening

HRSA promulgates the "Women's Preventive Services Guidelines," which are services that must be covered under the ACA.[22] Under these guidelines, women should be screened for urinary incontinence annually. Given the prevalence of urinary incontinence, the fact that many women do not volunteer symptoms, and the multiple risk factors, annual screening is merited.

Sexually Transmitted Infections (STIs) Screening

STI Behavioral Counseling. The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs) via multiple concurrent

[19] American College of Physicians, Inc.," Medicare-Covered Preventive Services" , 2013 https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/iii8-medicare-covered-preventive-services.pdf

[20] HealthyPeople.gov, "Osteoporosis to Prevent Fractures: Screening", Oct 8, 2020. https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/osteoporosis-to-prevent-fractures-screening#:~:text=The%20U.S.%20Preventive%20Services%20Task,the%20USPSTF%20recommends%20the%20service.

[21] US Preventative Services Task Force, "Osteoporosis to Prevent Fractures: Screenings", June 26, 2018. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening

[22] Health Resources and Services Administration, "Women's Preventive Services Guidelines", 2019. https://www.hrsa.gov/womens-guidelines-2019

partners and unprotected intercourse.[23] This is a "B" recommendation. Behavioral counseling interventions for individuals seeking primary health care were associated with reduced incidence of STIs.

Preexposure Prophylaxis (PrEP). Additionally, the USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.[24] The USPSTF determined there is a net benefit in receiving PrEP. While associated with small harms (e.g. renal and gastrointestinal adverse effects), PrEP offers substantial benefit in decreasing the risk of HIV infection.

Chlamydia Screening. The USPSTF recommends ("B" recommendation) chlamydia screenings in sexually active women under the age of 24 and in older women who are at increased risk for infection.[25] There is direct evidence that screening for chlamydia in women who are at increased risk for infection is associated with moderate benefit, including reduced incidence of pelvic inflammatory disease (PID) in women and improved infant and maternal outcomes in pregnant women. The USPSTF found that screening for chlamydia is associated with harms that are small to none. However, the USPSTF found little direct evidence on the effectiveness of chlamydia screenings for men or low-risk women ("I"), especially due to its low prevalence in these groups. Chlamydial infection may cause epididymitis in men, but serious complications are not common.[15]

Gonorrhea Screening. The USPSTF recommends gonorrhea screenings in sexually active women under the age of 24 and in older women who are at increased risk for infection ("B"). The USPSTF found that screening for gonorrhea is associated with harms that are small to none and that indirect evidence shows moderate benefit of gonorrhea screening in women at increased risk.[15] However, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of gonorrhea screenings in men or low-risk women ("I"), especially due to its low prevalence in these groups. Additionally, the majority of infections in men are symptomatic, which can result in more timely diagnosis and treatment that prevents serious complications.[15]

Syphilis Screening. The USPSTF recommends ("A") screenings among asymptomatic, non-pregnant adults and adolescents who are at increased risk.[26] Similarly, the USPSTF recommends ("A") early screening for syphilis infection in all pregnant women.[27] Accurate screening tests are available to identify syphilis infection in populations at increased risk. Additionally, effective treatment with antibiotics can prevent progression to late-stage disease, as well as significantly decrease adverse pregnancy outcomes, with small associated harms, providing an overall substantial health benefit.

HIV Screening. The USPSTF highly recommends ("A") HIV infection screenings in adolescents and adults aged 15 to 65 years.[28] Younger adolescents and older adults who are at increased risk of infection should also be screened. Additionally, the USPSTF highly recommends ("A") HIV infection screenings in all pregnant persons. The USPSTF determined with high certainty that early detection and treatment of HIV infection

[23] US Preventative Services Task Force, "Sexually Transmitted Infections: Behavioral Counseling", August 18, 2020. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling
[24] US Preventative Services Task Force, "Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis", June 11, 2019. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
[25] US Preventative Services Task Force, "Chlamydia and Gonorrhea: Screening", September 22, 2014. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening
[26] US Preventative Services Task Force, "Syphilis Infection in Nonpregnant Adults and Adolescents: Screening", June 07, 2016. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-nonpregnant-adults-and-adolescents
[27] US Preventative Services Task Force, "Syphilis Infection in Pregnant Women: Screening", September 04, 2018. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-pregnancy-screening
[28] US Preventative Services Task Force, "Human Immunodeficiency Virus (HIV) Infection: Screening", June 11, 2019. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

would result in substantial benefits. Screening for HIV infection would allow for earlier and expanded detection of HIV infection, thus resulting in earlier medical and behavioral interventions and treatment.

Genital Herpes Screening. The USPSTF recommends against routine screening for genital herpes simplex virus (HSV) infection in asymptomatic adolescents and adults, including those who are pregnant ("D").[29] While the genital herpes simplex virus infection can be detected through tests, such screening in asymptomatic persons will likely result in a large number of false-positive results. Given the limitations of currently available tests, 1 of 2 positive results may be false. There are social and emotional harms of receiving a false-positive result, in addition to the potential harms of unnecessary treatment with preventive antiviral medications. However, antiviral medications are generally considered to have few harms in nonpregnant adults.

State Actions

In response to numerous and consistent efforts to repeal the ACA, states have taken legislative measures to codify ACA consumer protections into state law. Such state-level action has been unevenly accomplished. Twenty-five states have not codified any components of the ACA, while ten states have adopted all of the ACA's four pillars and fifteen have codified between one to three pillars.[30] Below is a selection of state action.

State	Legislation/Statute	Summary
California	AB 414 (Enacted-2020)	Directly incorporates ACA minimum coverage requirements into state law to ensure an individual and the individual's spouse and dependents maintain minimum essential coverage.
Connecticut	HB 5210 (Enacted-2018)	Directly incorporates ACA consumer protections into state law relating to essential health benefits, and preventive services.
District of Columbia	§ 47–5104 (Enacted-2019)	Codifies ACA consumer protections by requiring minimum essential coverage and establishing a general hardship exemption from the shared responsibility payment requirement.
Louisiana	SB 173 (Enacted-2019)	Directly incorporates ACA consumer protections into state law relating to essential health benefits, if the Supreme Court invalidates the federal law.
Maine	LD 1 (Enacted-2019)	Directly incorporates ACA consumer protections into state law relating to essential health benefits and cost-sharing limitations.
New Hampshire	SB 4 (Enacted—2019)	Directly incorporates ACA consumer protections into state law (all but out-of-pocket maximums).
New Jersey	14 different bills (Enacted-2019)	Directly incorporates ACA consumer protections into state law.
New Mexico	HB 436 (Enacted-2019)	Directly incorporates ACA consumer protections into state law.
Oregon	SB 250 (Enacted-2019)	Directly incorporates ACA consumer protections into state law relating to essential health benefits.
Virginia	SB 95 (Enacted-2020)	Directly incorporates ACA consumer protections regarding essential health benefits and preventative care.

[29] US Preventative Services Task Force, "Genital Herpes Infection: Serologic Screening", December 20, 2016. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/genital-herpes-screening

[30] The Commonwealth Fund, "State Efforts to Protect Preexisting Conditions Unsustainable Without the ACA", October 29, 2020. https://www.commonwealthfund.org/blog/2020/state-efforts-preexisting-conditions

This Legislation

Mandatory Coverage Provisions for State-Regulated Private Health Insurance Plans

The bill adds HRSA guidelines as a source for requiring coverage for a particular preventive health care service. Currently, state statute only lists the USPSTF.

The bill removes the word "unhealthy" from the section relating to alcohol use screening and adds counseling for alcohol use. The bill adds language to include expanded tobacco intervention and counseling for pregnant individuals who use tobacco products. The bill adds the following services to statute to receive mandatory coverage:

- Abdominal aortic aneurysm screening
- Aspirin-preventive medication
- Blood pressure screening
- Diabetes screening for adults and gestational diabetes screening
- Health diet and physical activity counseling to prevent cardiovascular disease
- Falls prevention for adults over the age of 65 who live in a community setting
- Hepatitis B and Hepatitis C screening
- HIV screening
- Lung cancer screening
- Obesity screening and counseling
- Counseling, prevention, screening, and treatment of a STI[31], provided regardless of gender
- Statin preventive medication for adults
- Tuberculosis screening
- Anemia screening on a routine basis
- Comprehensive breastfeeding support and counseling from trained providers and access to breastfeeding supplies for pregnant and nursing individuals
- Folic acid supplements for individuals who may become pregnant
- Preeclampsia screening and treatment in pregnant individuals, including blood pressure measurements throughout pregnancy and low-dose aspirin after 12 weeks gestation for pregnant women who are at high risk
- Rh incompatibility screening for all pregnant individuals and follow-up testing for individuals at higher risk for incompatibility
- Urinary tract, yeast, or other infection screening
- Domestic and interpersonal violence screening and counseling
- Osteoporosis screening for all adults over the age of 60
- Annual urinary incontinence screening
- All contraception
- Family planning and family planning-related services
- Any other preventive services included in the A or B recommendations of the USPSTF or HRSA guidelines or as required by federal law

These added services are not required for grandfathered health benefit plans.

STI Treatment for Minors

Currently, if a minor requests that a health provider or facility perform an exam for a STI then they are to treat the minor, if necessary, for a STI as well as discuss prevention measures. The bill adds that the provider

[31] Defined in C.R.S. § 25-4-402(10) as "Sexually transmitted infection" refers to chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infection, regardless of mode of transmission, as designated by the state board by rule upon making a finding that the particular sexually transmitted infection is contagious.

or facility is to administer, dispense, or prescribe preventive measures or medications where applicable. The consent of a parent or legal guardian is not required for the minor to receive STI preventive care.

Medicaid Family Planning Services

Currently, when medical or diagnostic services are provided by a certified family planning clinic, Medicaid is to reimburse those services. The bill amends this language to state when family planning or family planning-related services are provided under Medicaid, no matter the facility, Medicaid is to reimburse for those services. These services are not subject to policy deductibles, copayments, or coinsurance. Any recipient may obtain these services from any licensed health care provider, including but not limited to a doctor of medicine, doctor of osteopathy, physician assistant, or advanced practice nurse. The enrollment of a recipient in a managed care organization, or a similar entity, does not restrict the patient's choice of the licensed provider from whom they can receive these services.

Family planning-related services means any medically necessary health care, counseling services, or medication focused on or related to the treatment of medical conditions routinely diagnosed during a family planning visit. This includes treatment for a urinary tract infection, the testing, diagnosis, treatment, and prevention of STIs or other infections/conditions of the urogenital system, and the treatment of medical complications resulting from a family planning visit.
Family planning services means any health care or counseling services focused on preventing, delaying, or planning for a pregnancy, which must include medically necessary evaluation or preventive services

This bill takes effect January 1, 2023.

Reasons to Support

The bill would ensure Coloradans can continue to obtain the evidence-based preventive services they are now accustomed to receiving under the ACA, regardless of the fate of the ACA. By ensuring the regularity, affordability, and accessibility of preventive care, this bill helps to maximize the quality of health care in Colorado. Such maintenance of preventive care is key to reducing expensive bills and reductions in coverage that weigh heavily on the budgets of patients, providers, and the state.

Additionally, by expanding the range of covered preventive services (e.g. osteoporosis and urinary incontinence screenings, as well as the counseling, prevention, screening, and treatment of any STI), this bill ensures Coloradans receive more holistic and comprehensive care. With more services covered by insurance, fewer medical conditions and patients are likely to fall through the cracks. The bill also increases the accessibility of family planning services, as Medicaid patients would no longer be limited to family planning clinics. Such accessibility is important for patient care, especially in communities that suffer from a shortage of medical providers.

Supporters

- AMGEN
- Colorado Academy of Family Physicians
- Colorado Children's Campaign
- Colorado Consumer Health Initiative
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Gilead Sciences Inc.
- Interfaith Alliance
- Planned Parenthood of the Rocky Mountains
- Violence Free Colorado

Reasons to Oppose

The bill requires preventive services to be expanded beyond the current ACA list of preventive services recommended by USPSTF, HRSA, and NAM to include osteoporosis screenings for men, urinary incontinence screenings for men, and expanded coverage for the counseling, prevention, screening, and treatment of any STI. The USPSTF has concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men. Similarly, the bill requires coverage of STI screenings for both women and men, but the USPSTF has also found no identifiable benefit for men to receive some STI screenings. Additionally, the bill adds STI treatment to the list, much of which is currently not required to covered under the ACA. Requiring screenings that have not been proven to be necessary for good health outcomes would unnecessarily strain the resources of both insurance companies and providers, while possibly raising the premiums for all enrollees.

Due to these additions, the bill may not decrease overall health care costs for patients. Insurance companies may raise premiums to cover the costs of the wider net of cost-sharing free preventive services. The increased amount of requirements and regulations could be burdensome for insurance companies. The bill does not consider whether the state has sufficient medical provider capacity to match a potential increase in demand for the proposed newly covered services.

Opponents

- Any opposition has not yet been made public

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

3/5/2021

STAFF: ALYSON WILLIAMS POLICY BRIEF

SB21-085: ACTUARIAL REVIEW HEALTH INSURANCE MANDATE LEGISLATION

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

Details

Bill Sponsors:	Senate – Ginal (D) and Smallwood (R) House – Lontine (D)
Committee:	Senate Finance Committee
Bill History:	2/16/2021- Introduced in House
Next Action:	Hearing in Senate Finance Committee

Background

The purpose of this policy brief is to provide an overview of the bill to the Board of Directors before discussion at the March 9, 2021 Board meeting.

Bill Summary

Actuarial Review

By November 1, 2021, the Division of Insurance (DOI) is to retain a contractor that has experience with health care policy and actuarial reviews. The contractor is to perform actuarial reviews on proposed legislation that may impose a new health benefit mandate on health plans. Under the direction of the DOI, the contractor is to conduct such reviews of up to 5 legislative proposals that are being or will be considered for each regular session, at the request of a legislator. If the DOI gets more than 5 requests, the chair of the House Health & Insurance Committee and the chair of the Senate Health & Human Services Committee shall select which legislative proposals the contractor is to review.

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

- An estimate of the number of Coloradans who will be directly affected by the proposal
- Estimates of changes in the rates of utilization of specific health care services that may result from the proposal
- Estimates for any changes in consumer cost sharing that would result from the proposal
- Estimates of any premium increases for plans on the individual, small-group, and large-group markets (in terms of percentage increase as well as per-member, per-month charges)
- An estimate of the increases, if any, in the cost of coverage for the state employee group benefit plans, regardless of whether the proposal amends that section of statute or applies to the plans (in terms of dollar amounts)
- An estimate of the increase in expenditures for Medicaid, if any, regardless whether the proposal amends that section of statute (in terms of dollar amounts)
- An estimate of the increase in cost of coverage, if any, that would result from the proposal for employers with fewer than 100 employees, between 100 and 500 employees, and employers with 500 or more employees (in terms of dollar amounts)
- An estimate of the potential long-term cost savings associated with any new benefit or service described in the proposal (in terms of dollar amounts)
- Identification of any potential health benefits that would result from the proposal

In performing these reviews, the contractor shall utilize data from the all-payer claims database. Carriers are encouraged to provide information to and cooperate with the contractor and the DOI.

Fiscal Notes

In preparing a fiscal note, Legislative Council Staff is to include the information produced by the contractor (to the extent practicable) as well as an indication of how the contractor's entire report can be obtained. If no information is produced by the contractor for the proposal, that fact must be indicated in the fiscal note.

Repeal

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

Effective Date

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

Supporters

- America's Health Insurance Plans
- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Association of Health Plans
- Colorado Competitive Council
- Colorado Hospital Association
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Colorado State Association of Health Underwriters
- Craig Hospital
- CVS Health
- Denver Health
- Denver Metro Chamber of Commerce
- Kaiser Permanente

Opponents

- 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 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

3/5/2021

STAFF: ALYSON WILLIAMS ISSUE SUMMARY

SB21-XXX: PRESCRIPTION DRUG AFFORDABILITY BOARD

Details

Bill Sponsors: Senate – Jaquez Lewis (D) & Gonzales (D)
House – Caraveo (D) & Kennedy (D)

Background

The purpose of this issue summary is to provide an overview of the issue being addressed by the coming bill that is being finalized after publication deadline.

Bill Summary

The bill establishes a Prescription Drug Affordability Board (PDAB) to conduct affordability reviews and set upper payment limits on certain expensive prescription drugs.

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.[2]

From 2017 until 2026 prescription drug spending is anticipated to increase 6.3 percent per year.[3] Out-of-pocket costs for patients was $82 billion in 2019, but each patient's exposure to these costs varied dramatically.[4] For example, only 1.1 percent 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.[5] Approximately 58 percent of Americans report that they are currently taking at least one prescription drug while 25 percent take four or more prescription drugs.[6] A 2015 Consumer Reports poll found that 30 percent of people who take at least one prescription drug a month had unexpected spikes in the out-of-pocket cost of their drug(s) in the past year.[7]

In 2019, 9 percent of all new prescriptions were abandoned at retail pharmacies.[8] Abandonment represents patient care that is recommended by a provider but not received. Abandonment rates are less than 5

[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] Ibid.
[3] 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
[4] 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
[5] Ibid.
[6] 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/
[7] *Impact of Surging Drug Prices on Consumers: Hearings before the Democratic Steering and Policy Committee,* House, 114th Congress (2015) (Testimony of Lynn Quincy). Retrieved from http://www.healthcarevaluehub.org/files/3214/4969/6175/Consumers_Union_Drug_Prices_Testimony.pdf
[8] 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

percent when the prescription carries no out-of-pocket cost, but it rises to 45 percent when the cost is over $125 and 60 percent when the cost is over $500.[9]

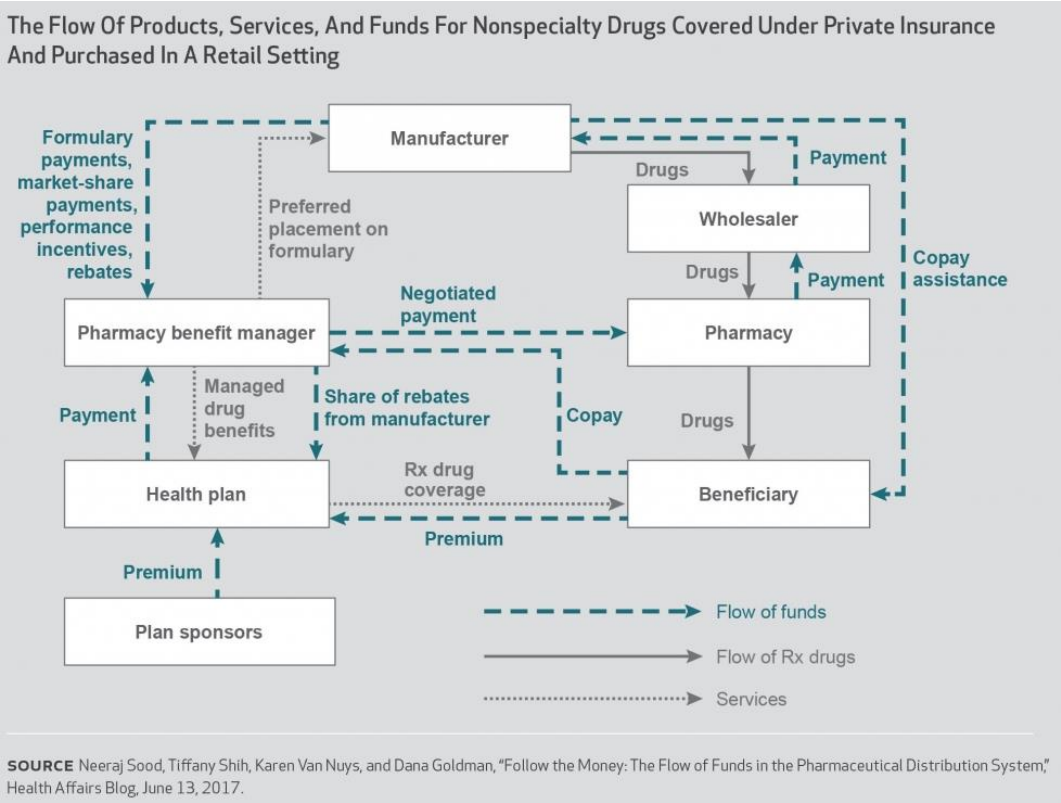
Prescription Drugs in Colorado

In 2019, more than 43.7 million prescription drugs were filled at pharmacies in Colorado, resulting in $6.74 billion of retail sales.[10] According to the Colorado Health Institute's (CHI) 2019 Colorado Health Access Survey, 10.8 percent of Coloradans cite the cost of prescription drugs as reason for not filling the medicines they are prescribed.[11]

In the 2019 Community Health Survey conducted by the Health District of Northern Larimer County, 55.1 percent 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 percent of adult Larimer County residents reported being unable to have a prescription filled because they could not afford it during the preceding two years.[12] This rate is much higher among those who reported being uninsured (22.1 percent) and those who fell between 186 and 400 percent of the Federal Poverty Level (FPL)[13] (19.1 percent).

Supply Chain

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



[9] Ibid.
[10] Henry J Kaiser Family Foundation (2020). *Health Costs & Budgets Indicators,* Retrieved from https://www.kff.org/state-category/health-costs-budgets/prescription-drugs/
[11] 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
[12] With a 95% confidence interval ranging from 8% to 11.7%.
[13] The 2018 version of the Federal Poverty Level was utilized in the survey.

Brand-Name Drugs

The Federal Drug Administration (FDA) utilizes a structured framework for the approval all new brand-name drugs. To grant approval, the agency conducts an analysis of the target condition and other treatments in the market for the condition, assesses the benefits and risks of the drug, and evaluates risk-management strategies.[14] From preclinical testing to approval the average length of time for a new drug is 12 years, this time may be quicker due to the various designations and programs.[15] Brand-name drug sales accounted for 80.0 percent of total prescription drug revenue in 2019.[16] During the same year, 16 percent of patients that had commercial insurance used coupons to reduce their out-of-pocket costs.[17] A 2019 study found that 78 percent of 49 common top-selling brand-name drugs have seen an increase in both insurer and patient out-of-pocket costs by more than 50 percent, and 44 percent of the studied drugs have more than doubled in price.[18]

Generic Drugs

Generic drugs are identical to their brand-name counterparts and work in the same manner. These generics must be approved by the FDA and can only go to market after the patents and regulatory exclusivities have expired for the brand-name drug. The generic dispensing rate, which measures the proportion of drugs that are dispensed as generic rather than as brand-name, continued to grow in 2019, reaching 86.3 percent, an increase from 85.5 percent in 2018.[19] Generics are typically sold at prices that are 80 to 85 percent less than the cost of a brand-name drug.[20]

Specialty Drugs

The definition of a specialty drug is highly dependent on the entity utilizing the phrase, thus the definition can vary widely. The IQVIA Institute, defines it as a drug that treats a complex, chronic, or rare disease, and has at least four of the following characteristics: list price over $6,000 per year, maintained by a specialist medical provider, not self-administered, requires special handling in supply chain, requires patient payment assistance, distributed through non-traditional channels, and/or has significant side effects that require patient monitoring. [21] For 2019, Medicare defined a specialty tier drug as one that costs more than $670 per month.[22] The anticipated growth in prescription drug spending over the next decade is largely attributable to a larger percentage of that spending on specialty drugs.[23] Specialty drugs accounted for 46.5 percent of drug spending in 2017, a dramatic increase from 2012 (25%).[24,25] The use of specialty medicines grew by 5

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[14] U.S. Food and Drug Administration [FDA] (Jan. 2018). *Development & Approval Process (Drugs).* Retrieved from https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm

[15] Van Norman, G.A. (Apr. 2016). Drugs, Devices, and the FDA: Part 1: An Overview of Approval Processes for Drugs, *JACC Basic to Translational Science, 3*(1). DOI: https://doi.org/10.1016/j.jacbts.2016.03.002

[16] Martin, A.B., Hartman, M., Lassman, D., & Catlin, A. (Dec. 2020).National Health Care Spending in 2019: Steady Growth for the Fourth Consecutive Year, *Health Affairs 40*(1). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02022

[17] 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

[18] Wineinger, N.E., Zhang, Y., & Topol, E.J. (May 2019). Trends in Prices of Popular Brand-Name Prescription Drugs in the United States, *JAMA Netw Open.* 2019;2(5):e194791. doi:10.1001/jamanetworkopen.2019.4791

[19] Martin, A.B., Hartman, M., Lassman, D., & Catlin, A. (Dec. 2020).National Health Care Spending in 2019: Steady Growth for the Fourth Consecutive Year, *Health Affairs 40*(1). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.02022

[20] FDA (Jan. 2018). *Generic Drugs: Questions & Answers.* Retrieved from https://www.fda.gov/Drugs/ResourcesForYou/Consumers/QuestionsAnswers/ucm100100.htm#q4

[21] IQVIA Institute (Oct. 2017). *Orphan Drugs in the United States: Providing Context for Use and Cost.* Retrieved from https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/orphan-drugs-in-the-united-states.pdf

[22] Cubanski, J., Koma, W., & Neuman, T. (Feb. 1, 2019). Specialty Drugs in Medicare Part D in 2019. *Kaiser Family Foundation.* Retrieved from https://www.kff.org/medicare/issue-brief/the-out-of-pocket-cost-burden-for-specialty-drugs-in-medicare-part-d-in-2019/

[23] 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

[24] Kleinke, J.D., & McGee, N. (2015). Breaking the Bank: Three Financing Models for Addressing the Drug Innovation Cost Crisis. *American Health & Drug Benefits, 8*(3). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467013/

[25] IQVIA Institute (Apr. 19, 2018). *Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022.* Retrieved from https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022

percent in 2018, more than double the rate of other drugs.[26] Using pharmacy claims data from Colorado's All-Payer Claims Database (APCD), the Center for Improving Value in Health Care (CIVHC) estimates that across all payers[27] and prior to rebates, specialty drugs represent only 1-2 percent of drug claims volume, but account for 37-49 percent of total drug spending.[28]

Wholesale Acquisition Cost (WAC)

Also known as list price, the wholesale acquisition cost (WAC) is similar to a suggested retail price created by the manufacturers for wholesalers or direct purchasers and is only occasionally relevant to the pricing of both generic and brand-name drugs.[29] Thus, the WAC is not based on any actual sales of a drug. It is defined in federal Medicaid statute as "the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price."[30] The WAC serves as a basis for negotiations between entities in the supply chain.

Prescription Drug Affordability Boards (PDAB) in Other States

Six states (Maine, Maryland, Massachusetts, New Hampshire, New York, and Ohio) have enacted legislation to establish drug affordability boards or commissions. The most common approach that these boards use to reduce prescription drug prices is through setting upper payment limits, however, other approaches have included negotiating supplemental rebates and formulary changes.[31] The payers under the purview of such a Board have included state-sponsored insurance, state-regulated insurance, and Medicaid.

Maryland's General Assembly authorized the creation of a Prescription Drug Affordability Board, as well as an advisory council, in 2019.[32] The Board was charged in statute to study the entire pharmaceutical distribution and payment system in Maryland and the policy options being used in other states and countries to lower the list price of pharmaceuticals (i.e. upper payment limits, reverse auction marketplaces, and bulk purchasing).

About this Issue Summary

This issue summary 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 and behavioral health, dental, preventive and health planning services to the communities it serves. This issue summary 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.

[26] IQVIA Institute (May 2019). *Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023.* Retrieved from https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023

[27] Includes commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service Part D

[28] CIVHC (Jan. 2021). *Colorado prescription drug spending and the impact of drug rebates: a summary of payer-reported prescription drug spending and drug manufacturer rebates and other compensations, 2016-2018.* Retrieved https://www.civhc.org/wp-content/uploads/2021/01/CO-Drug-Rebate-Report_1.8.2020.pdf

[29] Meador, M. Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry through Regulation.

[30] 42 USC § 1395w-3a(c)(6)(B)

[31] Manatt, Phelps & Phillips (Nov 2020). *State Drug Affordability Boards: Legislative Landscape and Future Implications.* Retrieved from https://www.jdsupra.com/legalnews/state-drug-affordability-boards-53701/

[32] Maryland Prescription Drug Affordability Board (2021). *Maryland Prescription Drug Affordability Board.* Retrieved from https://pdab.maryland.gov/index.html

Health District
OF NORTHERN LARIMER COUNTY

Priority 1 Bills

HB21-1005 Health Care Services Reserve Corps Task Force

Sponsors: K. Mullica (D) | Y. Caraveo (D) / L. Garcia (D)

Summary:

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

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

HB21-1012 Expand Prescription Drug Monitoring Program

Sponsors: J. Rich (R) | K. Mullica (D) / B. Pettersen (D) | D. Coram (R)

Summary:

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

HB21-1021 Peer Support Professionals Behavioral Health

Sponsors: R. Pelton (R) | Y. Caraveo (D)

Summary:

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 this bill as introduced.)

Status: 2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

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HB21-1025 Nonsubstantive Emails And Open Meetings Law

Sponsors: J. Arndt (D) / J. Ginal (D)

Summary:

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
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs
2/22/2021 House Committee on State, Civic, Military and Veterans Affairs Refer Unamended to House Committee of the Whole
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

HB21-1030 Expanding Peace Officers Mental Health Grant Program

Sponsors: J. McCluskie (D) | H. McKean (R) / J. Buckner | J. Cooke (R)

Summary:

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

HB21-1032 Local Government Authority Statewide Disaster Declarations

Sponsors: S. Luck

Summary:

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

HB21-1036 Local Control Of Health Orders

Sponsors: A. Pico

Summary:

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

HB21-1050 Workers' Compensation

Sponsors: M. Gray (D) | K. Van Winkle (R) / J. Bridges (D) | J. Cooke (R)

Summary:

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

HB21-1051 Public Information Applicants For Public Employment

Sponsors: T. Geitner (R) | S. Bird (D)

Summary:

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.
(Note: This summary applies to this bill as introduced.)

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

HB21-1054 Housing Public Benefit Verification Requirement

Sponsors: D. Jackson (D) / J. Gonzales (D)

Summary:

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
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & 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

HB21-1058 Promoting Social Distancing In Marijuana Industry

Sponsors: M. Gray (D) / J. Gonzales (D)

Summary:

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

HB21-1068 Insurance Coverage Mental Health Wellness Exam

Sponsors: D. Michaelson Jenet (D) | B. Titone (D) / D. Moreno (D)

Summary:

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

HB21-1074 Immunity For Entities During COVID-19

Sponsors: M. Bradfield

Summary:

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
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs

HB21-1075 Replace The Term Illegal Alien

Sponsors: S. Lontine (D) / J. Gonzales (D)

Summary:

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
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & 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

HB21-1081 Disaster Emergency Duration Limits

Sponsors: A. Pico

Summary:

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
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs

HB21-1085 Secure Transportation Behavioral Health Crisis

Sponsors: J. McCluskie (D) | C. Larson (R) / J. Bridges (D) | J. Smallwood (R)

Summary:

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

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HB21-1097 Establish Behavioral Health Administration

Sponsors: M. Young (D) | R. Pelton (R) / R. Fields (D)

Summary:

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 this bill as introduced.)

Status: 2/16/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

HB21-1106 Safe Storage Of Firearms

Sponsors: M. Duran (D) | K. Mullica (D) / J. Bridges (D) | C. Hansen (D)

Summary:

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.

(Note: This summary applies to this bill as introduced.)

Status: 2/16/2021 Introduced In House - Assigned to State, Civic, Military and Veterans Affairs
2/16/2021 Introduced In House - Assigned to State, Civic, Military, & Veterans Affairs
3/1/2021 House Committee on State, Civic, Military, & Veterans Affairs Refer Unamended to House Committee of the Whole
3/3/2021 House Second Reading Laid Over Daily - No Amendments
3/4/2021 House Second Reading Laid Over to 03/08/2021 - No Amendments

HB21-1107 Protections For Public Health Department Workers

Sponsors: Y. Caraveo (D) | T. Carver (R) / J. Bridges (D) | P. Lundeen (R)

Summary:

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 this bill as introduced.)

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

HB21-1108 Gender Identity Expression Anti-discrimination

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

Summary:

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;

- 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 this bill as introduced.)

Status: 2/16/2021 Introduced In House - Assigned to Judiciary

HB21-1110 Colorado Laws For Persons With Disabilities

Sponsors: D. Ortiz

Summary:

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

HB21-1115 Board Of Health Member Requirements

Sponsors: C. Kipp (D) | K. Mullica (D) / J. Ginal (D) | K. Priola (R)

Summary:

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.

(Note: This summary applies to this bill as introduced.)

Status: 2/16/2021 Introduced In House - Assigned to Transportation & Local Government

HB21-1119 Suicide Prevention, Intervention, & Postvention

Sponsors: J. Rich (R) | L. Daugherty / K. Donovan (D) | D. Coram (R)

Summary:

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: This summary applies to this bill as introduced.)

Status: 2/18/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

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HB21-1130 Expand Transition Specialist Program

Sponsors: D. Michaelson Jenet (D) | M. Bradfield

Summary:

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 this bill as introduced.)

Status: 2/23/2021 Introduced In House - Assigned to Public & Behavioral Health & Human Services

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SB21-009 Reproductive Health Care Program

Sponsors: S. Jaquez Lewis / Y. Caraveo (D)

Summary:

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

SB21-011 Pharmacist Prescribe Dispense Opiate Antagonist

Sponsors: R. Fields (D) / K. Mullica (D) | R. Pelton (R)

Summary:

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: This summary applies to this bill as introduced.)

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

SB21-014 Allocation Formula Colorado Child Care Program

Sponsors: B. Kirkmeyer

Summary:

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

SB21-016 Protecting Preventive Health Care Coverage

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

Summary:

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

SB21-018 Continutation Of Necessary Document Program

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

Summary:

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

SB21-021 Audiology And Speech-language Interstate Compact

Sponsors: J. Buckner | D. Hisey (R) / M. Young (D) | T. Carver (R)

Summary:

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.

(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

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SB21-022 Notification Requirements For Health Care Policy And Financing Audit

Sponsors: J. Bridges (D) | J. Smallwood (R) / M. Snyder (D) | H. McKean (R)

Summary:

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.

(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 Amended to Appropriations

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SB21-025 Family Planning Service For Eligible Individuals

Sponsors: B. Pettersen (D)

Summary:

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

SB21-027 Emergency Supplies For Colorado Babies And Families

Sponsors: B. Pettersen (D) / S. Gonzales-Gutierrez (D) | K. Tipper (D)

Summary:

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

SB21-028 Promulgation Of Public Health Rules And Orders

Sponsors: B. Kirkmeyer

Summary:

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

SB21-036 Additional Requirements Issue Emergency Public Health Order

Sponsors: B. Gardner (R)

Summary:

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

SB21-064 Retaliation Against An Elected Official

Sponsors: L. Garcia (D) | J. Cooke (R) / K. Mullica (D)

Summary:

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.

(Note: This summary applies to this bill as introduced.)

Status: 2/16/2021 Introduced In Senate - Assigned to Judiciary + Appropriations

SB21-077 Remove Lawful Presence Verification Credentialing

Sponsors: J. Gonzales (D) / A. Benavidez (D) | C. Kipp (D)

Summary:

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 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: This summary applies to this bill as introduced.)

Status: 2/16/2021 Introduced In Senate - Assigned to Business, Labor, & Technology

SB21-080 Protections For Entities During COVID-19

Sponsors: R. Woodward (R) / S. Bird (D) | M. Bradfield

Summary:

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

SB21-085 Actuarial Review Health Insurance Mandate Legislation

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

Summary:

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

SB21-089 Cancer Screening Services Through Colorado Department Of Public Health And Environment

Sponsors: J. Buckner

Summary:

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

SB21-090 Small Group Health Insurance Plan Renewal

Sponsors: J. Smallwood (R) / E. Hooton (D)

Summary:

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

SB21-122 Opiate Antagonist Bulk Purchase And Standing Orders

Sponsors: J. Ginal (D) / M. Froelich (D)

Summary:

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 this bill as introduced.)

Status: 2/23/2021 Introduced In Senate - Assigned to Health & Human Services

SB21-123 Expand Canadian Rx Import Program

Sponsors: J. Ginal (D) | D. Coram (R) / K. McCormick

Summary:

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 this bill as introduced.)

Status: 2/25/2021 Introduced In Senate - Assigned to Health & Human Services

SB21-126 Timely Credentialing Of Physicians By Insurers

Sponsors: R. Fields (D) / D. Michaelson Jenet (D)

Summary:

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

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.

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.

(Note: This summary applies to this bill as introduced.)

Status: 2/25/2021 Introduced In Senate - Assigned to Health & Human Services

SB21-127 Department Of Regulatory Agencies Regulator Authority During Declared Emergency

Sponsors: J. Ginal (D) / K. Mullica (D)

Summary:

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

SB21-129 Veteran Suicide Prevention Pilot Program

Sponsors: L. Garcia (D) / D. Ortiz

Summary:

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

SB21-130 Local Authority for Business Personal Property Tax Exemption

Sponsors: C. Holbert (R) / K. Van Winkle (R)

Summary:

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 this bill as introduced.)

Status: 2/25/2021 Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Memorandum

Date: March 5, 2021

To: Health District Board of Directors

From: Karen Spink, Assistant Director

Subject: Community-Based COVID-19 Vaccine Equity Initiative

Several community organizations and individuals have come together to develop a community based solution to ensure effective equitable distribution of the COVID-19 vaccines in Larimer County, specifically in reaching Latinx, Immigrant, Black, and Indigenous community members and those at the intersections of those identities. This group is a powerful, well-established network of leaders and service providers within the BIPOC and immigrant communities in the county, which includes the following organizations:

- The BIPOC Alliance of Larimer County
- The Family Center / La Familia
- Fuerza Latina
- Alianza Norco
- La Cocina
- ISAAC and the Emergency Immigration Fund
- Queen's Legacy Foundation
- Foothills Unitarian Church

The proposed solution was developed in consultation with the following individuals:

- Betty Aragon and Mujeres de Colores
- Pat Griego, Latino Council, Cultural Enrichment Center, the Black / African American Center at CSU
- Pastor David Williams, Abyssinian Christian Church
- Sergio Torres, Larimer County
- Leah Schultz, Salud
- Claudia Menendez, Poudre School District
- MJ Jorgenson and Dr. James Stewart, Health District of Northern Larimer County

Each organization is deeply committed to racial health equity and are actively engaging in addressing the root causes of vaccine hesitancy and have been strategizing ways to increase vaccine acceptance and access. Several barriers to effective vaccine distribution were identified by this group, including lack of trust (including lack of trust in government offices), lack of access, and lack of coordination. In response to these identified barriers, the group developed a proposal for a comprehensive, community-integrated solution. The intent is to collaboratively work together to complement efforts that are being planned and implemented by Larimer County Department of Health by engaging established networks and trusted leaders from the BIPOC and immigrant communities.

The strategies identified by the group include:

- **Community-based Vaccination Education and Sign Ups.** Providing paid staffing for specific hotlines where staff will provide community-based education, answer questions, and assist individuals in signing up for appointments. Outreach, education, and assistance will also be expanded throughout the community via trusted community based providers.

- **Coordinated Community-based Mobile Vaccination Sites**. Coordinating and providing community-based mobile vaccination clinics to better reach the intended communities.

- **Coordination of Communication Strategies.** Developing a culturally informed marketing campaign for BIPOC and immigrant communities to grow trust and confidence, which includes development of robust communication and marketing tools and messages, engaging the stakeholders to align the communication messages, translation of all materials, placing and paying for paid media, and ensuring language justice services are available for all community-based conversations.

- **Addressing the Economic Impact of Vaccinations.** Includes funding for potential lost wages for time off to get the vaccines, to secure transportation to clinics, and for lost wages should the person experience significant side-effects after vaccination.

The collaborative reached out to United Way of Larimer County, the Bohemian Foundation, the County and the Health District last weekend to see if there was interest and ability to collaborate and provide funding to help support the project. At a meeting this week, all agencies expressed an interest in wanting to participate and were exploring options for being able to fund particular aspects of the proposal.

As this project directly aligns with both of the Health District's interests in ensuring the provision of COVID-19 vaccines to the community and our work with health equity, we strongly support engaging with this group and supporting their efforts. There are two particular areas where we feel could fit both within our areas of experience and expertise, and would work within our funding constraints. Those areas include:

- **Coordinated, Community Based Mobile Vaccination Sites:** Our staff (Dr. James Stewart and MJ Jorgensen) are already working with Salud and others on the community-based mobile vaccination sites effort and do not believe additional funding is needed to support our continued involvement.

- **Communication Coordination:** We propose the creation of a special project under our Health Equity workgroup to focus on Communication Coordination. Given the project's direct alignment with our equity focus, we would be able to provide both in-kind staff time and new funding to assist with things such as the convening of community stakeholder groups to enhance community outreach and engagement in vaccinations, working collaboratively with the BIPOC community to develop the culturally-attuned messages, supporting translation of COVID-19 Vaccination materials, and paying for both the coordination of and direct costs associated with targeted media buys. Our staff would also provide the support to develop and manage the contracts with the identified vendors.

  It is important to point out that the Health District's role would be in a supportive, rather than directive, role with the development of the messages - and materials would not be branded with our logo. It is critical to the success of this work for the messages to be developed and delivered by the communities in which we are trying to reach.

  While the group is still developing the scope of work, initial estimates are that the Health District would provide financial support between $50,000 and $60,000.

We are honored to be invited to the table to partner with this group and we are seeking the Health District Board of Director's approval required to commit up to $60,000 in funding through December 31, 2021 to support a collaborative community COVID-19 Vaccine Equity initiative with the BIPOC communities.