Health District
OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS SPECIAL MEETING

March 12, 2019
4:00 pm

Health District of Northern Larimer County
120 Bristlecone Drive
Fort Collins, CO

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OF NORTHERN LARIMER COUNTY

BOARD OF DIRECTORS SPECIAL MEETING
March 12, 2019
4:00 pm
Health District, 1st Floor Conference Room

AGENDA

4:00 p.m. **Board Refreshments**

4:05 p.m. **Call to Order; Introductions; Approval of Agenda**.....Michael Liggett

4:10 p.m. **PUBLIC COMMENT**
Note: If you choose to comment, please follow the "Guidelines for Public Comment" provided on the back of the agenda.

4:15 p.m. **DISCUSSION & ACTION**

- Policy: State Legislative Proposals..... Alyson Williams
  - HB19-1168: State Innovation Waiver Reinsurance Program
  - SB19-139: More Colorado Road & Community Safety Act Offices
  - HB19-1131: Prescription Drug Cost Education
  - HB19-1120: Youth Mental Health Education & Suicide Prevention
  - HB19-1009: SUD Recovery
- Update on key prior bills discussed

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

- Coloradans Struggle with Health Care Affordability but Agree on Solutions
  Report, Colorado Consumer Health Initiative ..... Alyson Williams/Carol Plock
- Increasing Public Awareness of the Health District.....Michael Liggett
  Further comments on Toolbox Creative ideas

5:15 p.m. **UPDATES**

- Staff Updates..... Carol Plock

5:20 p.m. **ANNOUNCEMENTS**

- March 26, 4:00 pm – Board of Directors Regular Meeting

5:25 p.m. **ADJOURN**

■ 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 eduation
- 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

GUIDELINES FOR PUBLIC COMMENT

The Health District of Northern Larimer County Board welcomes and invites comments from the public. 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.**

Health District
OF NORTHERN LARIMER COUNTY

3/8/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1168: STATE INNOVATION WAIVER REINSURANCE PROGRAM

Concerning the creation of the Colorado reinsurance program to provide reinsurance payments to health insurers to aid in paying high-cost insurance claims, and, in connection therewith, authorizing the commissioner of insurance to seek approval from the federal government to waive applicable federal requirements, request federal funds, or both, to enable the state to implement the program contingent upon waiver or funding approval

Details

Bill Sponsors:	House – *McCluskie (D) and Rich (R),* Buckner (D), Esgar (D), Kennedy (D), McLachlan (D), Roberts (D), Soper (R) Senate – *Donovan (D) and Rankin (R)*
Committee:	House Health & Insurance Committee
Bill History:	2/1/2019- Introduced- Assigned to Health & Insurance 2/27/2019- House Health & Insurance Refer Amended to House Appropriations
Next Action:	Hearing in House Appropriations
Fiscal Note:	2/26/2019 Version

Bill Summary

The bill creates a reinsurance program in the Division of Insurance, contingent on approval from the federal government, in order to reduce premium costs in the individual marketplace. The state share of the funding is generated through the creation of a fee schedule for reimbursement to providers and facilities for high claims costs individuals.

Issue Summary

Insurance in Colorado

Each of the 64 counties in Colorado currently has at least one carrier providing insurance. According to the 2017 Colorado Health Access Survey (CHAS), 93.5 percent are Coloradans are insured.[1] In Larimer County, 59 percent of residents reported being somewhat or very worried about health insurance becoming so expensive that they will not be able to afford it.[2] Only 4 percent of residents within the boundaries of the Health District of Northern Larimer County reported having no health insurance in 2016. [3] Additionally, 86 percent of Health District residents reported having continual health insurance during the preceding 3 years in the same survey.[3] However, cost is an issue that is at the forefront of consumer's minds. For those that are uninsured, 78.4 percent cited that the cost of the insurance was a barrier to purchasing coverage.[1]

In 2018, health insurance rates increased an average of 32.2 percent in the individual market in Colorado.[4] However, in 2019, plan premiums increased an average of 5.6 percent, although those eligible for advance premium tax credits (APTC) may have seen an average 24 percent decrease in premiums if they enrolled in

[1] Colorado Health Institute (2017). *Colorado's New Normal: Findings from the 2017 Colorado Health Access Survey.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf
[2] Larimer Health Tracker (2016). Retrieved from www.larimerhealthtracker.org
[3] 2016 Community Health Survey; note: 5 percent reported that they did not know if they had health insurance or not.
[4] Colorado Health Institute (April 2018). *Insurance Prices.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2018%20Final%20Rate%20Analysis.pdf

the same plan for 2019 that they had in 2018.[5] The mountain resort region of Summit, Pitkin, Eagle, and Garfield counties in Colorado were found in 2014 to be the most expensive for insurance in the entire United States.[6]

Cost of Care in Colorado

A 2018 report from the Network of Regional Healthcare Improvement (NRHI) demonstrates how Colorado compares to five other states, which were chosen as part of a pilot, for health care costs of those individuals that are commercially insured.[7] Colorado's risk-adjusted total cost per person in 2016 was 19 percent higher than the six-state average. Further analysis of the data by the Center for Improving Value in Health Care (CIVHC) found that Colorado has higher than average prices across all of the service categories, and was the only state of the six to have higher prices than average for these groups.[8] These higher than average prices for inpatient (31 percent), outpatient (15 percent), professional (7 percent) and pharmacy (5 percent) were found to be the main drivers of the higher total average spend per person. The utilization and price of these services also vary in different areas of the state. The figure below demonstrates that variance.[9]
A report from the Colorado Health Institute (CHI) and Colorado Hospital Association (CHA) found that 75 percent of the total spending by health service category in the state goes to hospitals (34 percent), physician, professional, and clinical services (29 percent), and insurance administrative costs (12 percent).[10] The remainder goes to nursing home/home health/other residential and personal care (10 percent), retail drugs (7 percent), medical equipment (3 percent), and other (5 percent).

Section 1332 Waivers

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

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

These guardrails were set forth in the statutory language, but can be interpreted differently by each administration. The Centers for Medicare and Medicaid Services (CMS) has created a detailed page guiding states through the 1332 waiver process, which was updated in October 2018.[11] The new guidance outlined that waiver applications that incorporate one or all of the listed principles are preferred by the agency:

1. Provide increased access to affordable private market coverage over public programs, and increase insurer participation and promote competition;

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[5] Division of Insurance (Oct. 4, 2018). *Division of Insurance releases state's 2019 health insurance plans and premiums.* Retrieved from https://www.colorado.gov/pacific/dora/news/division-insurance-releases-states-2019-health-insurance-plans-and-premiums
[6] Rau, J. (Feb. 2 2014) *The 10 Most Expensive Insurance Markets in the United States.* Kaiser Health News. Retrieved from https://khn.org/news/most-expensive-insurance-markets-obamacare/.
[7] NRHI (Nov. 8, 2018). *Healthcare Affordability: Data is the Spark, Collaboration is the Fuel.* Retrieved from http://www.nrhi.org/uploads/rwj_tcoc_phaseiii_benchmark_2018_r7.pdf
[8] CIVHC (Nov. 8, 2018). *Colorado's Health Care Costs Continue to Rise Above Other States.* Retrieved from https://www.civhc.org/2018/11/08/colorados-health-care-costs-continue-to-rise-above-other-states/
[9] Please note that the Center for Improving Value in Health Care is currently re-evaluating the data set regarding outpatient services; therefore, this data may change.
[10] Colorado Health Institute (2018). *Affordability in Colorado: Answers about Health Care Costs.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf
[11] The Centers for Medicare and Medicaid Services [CMS]. (2018) *State Relief and Empowerment Waivers.* Retrieved from https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf

2. Encourage sustainable spending growth by promoting more cost-effective coverage, restraining growth in federal spending, and eliminating state regulations that limit market choice and competition;
3. Foster state innovation;
4. Support and empower those in need; and
5. Promote consumer-driven health care.

The new guidance largely maintains the 2015 guidance's approach to budget neutrality.[12] However, a sentence was removed that stated that a waiver application that increases the deficit in any given year may not meet the deficit neutrality requirement. This suggests that a waiver could increase the federal deficit during the waiver's effect and still be approved (so long as the overall waiver does not increase the federal deficit).

Reinsurance

Reinsurance was designed as a way to cut the cost for insurance companies by paying a portion of the claims of their most expensive customers in the individual market, with the intent that the insurance companies can then lower insurance costs for their customers.[13] The simplest way to put it is that reinsurance is insurance for insurers. A reinsurance program and high-cost coverage can be designed in many ways. A traditional reinsurance program provides payments to insurers for high-cost claims.[11] In this type of program, eligibility can be based on either a threshold of the total of all claims or a threshold per each individual enrollee. Another way is to design a reinsurance program that creates a segregated group for certain conditions that are known to be high-cost to the insurers, this is known as a traditional high-risk pool.[14] This type of program is typically prospective, or looks into the future to expect a certain outcome, and separates customers into a high-risk pool based on being diagnosed with one of several identified conditions and provides insurers with a set amount of reinsurance payments based on the typical costs of a patient with that condition. Finally, a hybrid/invisible pool type design can either be retrospective (i.e. look into the past) or prospective and the individuals can either be in a single or separated risk pool.

It is important to understand key terms that relate to reinsurance. For a claims-based reinsurance program, the **'attachment point'** is the amount of a consumer's annual claims that trigger payments from a reinsurance program. The reinsurance's **'coinsurance rate'** is the percentage of claims costs above the attachment point that the reinsurance program pays to the insurer. The **'reinsurance cap'** is the maximum amount of annual claims that the reinsurance would make payments on to the insurer per high-cost consumer.

Reinsurance is being considered in state and national conversations because it provides a possible method for decreasing the risk for insurers. By doing so, this allows insurers to decrease premium costs for consumers as there is less uncertainty about how they will pay for all of their customer's claims in a given benefit year. Additionally, it may entice reluctant insurers into markets from which they had previously withdrawn due to high claims costs.

Rate Setting & Fee Schedules

Rate setting is the process of determining how much a payer, such as the state, will pay for a provider's service. A **fee schedule** is a list of the maximum rate a payer will allow for services, with the definition of

[12] Keith, K. (Oct. 23, 2018). Feds Dramatically Relax Section 1332 Waiver Guardrails. *Health Affairs Blog.* DOI: 10.1377/hblog20181023.512033

[13] Colorado Health Institute (April 2018). *A Game-Changer for High Insurance Prices?: Reinsurance Presents an Option to Aid a Troubled Market.* Retrieved from https://www.coloradohealthinstitute.org/research/game-changer-high-insurance-prices

[14] Division of Insurance, Colorado Department of Regulatory Agencies (Oct. 2, 2017). *A Report Regarding SB17-300: Colorado High-Risk Health Coverage Study.* Retrieved from https://leg.colorado.gov/sites/default/files/images/doi_sb17-300_study_final_report.pdf

services based on code sets such as the Current Procedural Terminology (known as CPT codes).[15] There are a variety of methods to set rates, such as using a rate based on the average market price, using a cost-based rate method, or tying a rate to a national benchmark, such as the Medicare Fee Schedule.[16] The Colorado Department of Health Care Policy and Financing (HCPF) currently sets rates and publishes a fee schedule for the Colorado Medicaid program, Health First Colorado.

Cover Colorado

Before the enactment of the ACA, the state had a program called Cover Colorado, which was a high-risk pool that operated from 1991 to 2013.[11] Each year there were approximately 13,700 individuals in the program with total claims of more than $117 million. The program was funded through monthly premium fees (50%), assessments on state regulated plans including stop loss and reinsurance (25%), and unclaimed property funds (25%). One of the issues with this high-risk pool program was that premium costs to individuals were much higher than traditional insurance. A consumer could get insurance even with a preexisting condition but only if they could afford the high costs. Due to the fact that this program was sunset in 2014, new legislation is required to create a reinsurance program and construct the waiver to apply for federal funds.

2017 Reinsurance Analysis for Colorado

Senate Bill (S.B.) 17-300 mandated that the Division of Insurance conduct a study of the different methods of providing health coverage to high-risk individuals and reducing premiums in the individual market. The study was contracted out to a highly experienced financial modeling firm, Milliman, which analyzed 25 different reinsurance scenarios.[17] The following chart demonstrates the projections that the actuarial analysis found in three scenarios for a reinsurance program.[8]

State of Colorado

2018 Illustrative Reinsurance Scenarios – Estimated Market Impact and Funding Requirements

	High	Medium	Low
Reinsurance Fund Size ($ Millions)	$296	$177	$59
Individual Market Premium Rate Reduction	-21%	-12%	-4%
Federal Pass-Through Percentage with Margin	40%	40%	40%
Federal Pass Through-Funding ($ Millions)	$119	$71	$24
State-Based Revenue Requirement ($ Millions)	$177	$106	$35

The analysis found that there would be at least two beneficial impacts of Colorado implementing a reinsurance program. First, it will likely decrease prices for those in the individual market that are not receiving subsidies from the Federal government. Also, the analysis asserts that the health status of the individual market risk pool may improve with additional enrollment from those who do not receive subsidies and may have otherwise forgone coverage.

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[15] Berenson, R.A., Upadhyay, D.K., Delbanco, S.F., and Murray, R. (Apr. 2016). Fee Schedules for Physicians and Other Health Professionals. *Urban Institute & Catalyst for Payment Reform.* Retrieved from https://www.urban.org/sites/default/files/01_fee_schedules_for_physicians.pdf

[16] HCPF (June 2016). *Establishing Provider Payment Rates and Methodologies: A Short Primer.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/Establishing%20Provider%20Payment%20Rates%20and%20Methodologies%20-%20A%20Short%20Primer.pdf

[17] Milliman, Inc. (Nov. 22, 2017). *Actuarial Report to the Colorado High-Risk Health Care Coverage Task Force, Final Report.*

Other States with Reinsurance Programs

Alaska was the first state to be approved to operate a reinsurance program in July 2017. The Alaska reinsurance program utilizes a prospective, hybrid condition-based model, under which 33 high-cost conditions are covered. Some examples of these high-cost conditions are multiple sclerosis, chronic hepatitis, HIV/AIDS, metastatic cancer, sickle cell anemia, and cystic fibrosis.[18] This program is funded with 81 percent federal funds and the remaining from the General Fund and assessments on all insurers.[11]

Minnesota, on the other hand, had their waiver approved in September 2017 for a retrospective, hybrid claims-based model, which is funded with a combination of state and federal funds. Minnesota's program has an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000.[11] The state funding of this program comes from the state's General Funds and the Health Care Access Fund, which is financed through a 2 percent provider assessment. [19]

Oregon's request for federal funding to finance the Oregon Reinsurance Program, a claims-based model, was approved in October 2017.[20] This program has a coinsurance rate of 50 percent between the attachment point (yet to be determined) and a cap of approximately $1 million. The state portion of the funding is financed through a 1.5 percent assessment on fully insured commercial major medical premiums. [21]

The 1332 Waiver application submitted to support the reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA) was approved by CMS in July 2018. The program is condition-based and will reimburse insurers 90 percent of claims paid between $47,000 and $77,000, then 100 percent of claims in excess of $77,000 for those individuals that have certain health conditions. [22] The source of state funds is an assessment on insurers of $4 per member per month, 90 percent of an underlying insurance premium of a policy ceded to the program, one-time $500 fee on licensed insurers, and the optional assessment of $2 per member per month to cover any net losses.[23]

During the same time, Wisconsin's reinsurance program, the Wisconsin Healthcare Stability Plan, was approved by the federal government. A claims-based reinsurance program, the program had a coinsurance rate of 50 percent for the 2019 plan year for claims between $50,000 and $250,000.[24] The state share of the program is funded by General Fund appropriations.

Maryland has a claims-based reinsurance program that was approved in August 2018 that has a yet to be determined attachment point[25] but with a cap of $250,000 and an 80 percent coinsurance rate, which is

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[18] McCormick, D., Leif, L., & Bykek, C. (June 21, 2018). Reinsurance: Saving the Individual Market. *Presented at NAIC Insurance Summit.* Retrieved from https://www.naic.org/insurance_summit/documents/insurance_summit_2018_GE_04.pdf

[19] State Health Access Data Assistance Center (Dec. 2018). *Resource: 1332 State Innovation Waivers for State-Based Reinsurance.* Retrieved from https://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

[20] Kaiser Family Foundation. (Aug 23, 2018). *Tracking Section 1332 State Innovation Waivers*. Retrieved from https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

[21] State Health Access Data Assistance Center (Dec. 2018). *Resource: 1332 State Innovation Waivers for State-Based Reinsurance.* Retrieved from https://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

[22] Kaiser Family Foundation. (Aug 23, 2018). *Tracking Section 1332 State Innovation Waivers*. Retrieved from https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

[23] State of Maine (2018). *State of Maine Executive Summary and Application for Waiver under Section 1332 of the Patient Protection and Affordable Care Act.* Retrieved from https://www1.maine.gov/pfr/insurance/mgara/section_1332_innovation_waiver_application.pdf

[24] Wisconsin Office of the Commissioner of Insurance (April 18, 2018). *Wisconsin 1332 Waiver Application.* Retrieved from https://oci.wi.gov/Documents/Regulation/1332%20Waiver%20WI%20Application.pdf

[25] Most sources note that this would be determined by Fall 2018; however, that attachment point is not readily found through research.

subject to annual change.[26] This program is funded with a 2.75 percent assessment on Maryland health plans and Medicaid managed care organizations, based on annual net premiums.[27]

Also approved in August 2018, New Jersey's reinsurance program is a claims-based reinsurance program that has an attachment point of $40,000, a coinsurance rate of 60 percent and a cap of $215,000.[28] The state portion of the funding comes from the General Fund and the funds collected pursuant to the state shared responsibility tax, which is the state's individual mandate tax penalty.

Legislative History

During the 2018 legislative session, HB18-1392[29] was introduced by a bipartisan group of legislators and passed the House but was postponed indefinitely by the Senate Committee on State, Veterans, & Military Affairs at the end of the session. The bill was similar in the respect that it created a reinsurance program and tasked the DOI with applying for a 1332 waiver from the federal government; however, the state portion of the funding was gathered through an assessment on private insurance plans.

This Legislation

This bill is the "Colorado Reinsurance Program Act." The legislative declaration of the bill states that the General Assembly finds that all Coloradans deserve access to high-quality, affordable health care to support their well-being and economic security. The increasing costs of health care in Colorado have led to premium increases for health insurance in the individual market that have created a financial burden for some Coloradans that purchase insurance in the individual market. That burden is heightened in rural areas of the state, where premiums are considerably higher than in metropolitan areas and there is a lack of competition among health care providers and carriers. Because of that burden in rural areas, a considerable number of these cost-burdened consumers may not purchase health insurance, exacerbating the problems of few carriers, few plan options, and high insurance costs in rural regions, as well as increasing the number of uninsured Coloradans. The declaration states that Colorado has historically been a national leader in health care innovation and it is important to use that innovative spirit to address the rising costs in health care by directing the Commissioner of Insurance and the Division of Insurance (DOI) to create a reinsurance program that will:

- Make private health insurance in the individual market more accessible and affordable
- Encourage participation and competition by carriers throughout the state, but particularly in rural areas, to give consumers the ability to seek value in insurance coverage
- Decrease costs of care, leading to lower premiums and restraining or decreasing the growth in federal spending commitments in the individual market
- Support, empower, and increase access to affordable, high-value insurance for consumers who are ineligible for premium tax credit subsidies while minimizing potential negative effects on access to affordable, high-value insurance for consumers eligible for the premium tax credit subsidies and cost sharing reductions

The bill defines **"attachment point"** as the amount set by the DOI for claims costs incurred by an eligible carrier for a covered person's covered benefits during a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under the program. **"Behavioral health care services"** is defined as services for the prevention, diagnosis, and treatment of, and the recovery from behavioral,

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[26] CMS (Aug. 22, 2018). *Maryland: State Innovation Waiver under section 1332 of the PPACA.* Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/MD-Fact-Sheet.pdf

[27] State Health Access Data Assistance Center (Dec. 2018). *Resource: 1332 State Innovation Waivers for State-Based Reinsurance.* Retrieved from https://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

[28] New Jersey (July 2, 2018). *New Jersey 1332 Waiver Application.* Retrieved from https://www.state.nj.us/dobi/division_insurance/section1332/180702finalwaiverapplication.pdf

[29] The Board of Directors supported HB18-1392.

mental health, or substance use disorders. A **"benefit year"** is the calendar year for which an eligible carrier provides coverage through an individual health plan. The bill defines the **"coinsurance rate"** as the rate set by the DOI at which the program will reimburse an eligible carrier for claims incurred by a person during a benefit year, which claims are above the attachment point but are below the reinsurance cap. An **"eligible carrier"** is a carrier that offers individual plans that comply with Affordable Care Act and incurs claims costs for a covered person's covered benefits in the applicable benefit year. The **"fee schedule"** refers to the fee schedule to be established by the DOI. The term **"payment parameters"** includes the attachment point, reinsurance cap, coinsurance rate, and fee schedule. **"Primary care services"** is defined as health services regarding family medicine, general practice, general internal medicine, pediatrics, general obstetrics and gynecology, oral health, or mental health that are provided by health professionals. The **"reinsurance cap"** is the amount set by the DOI for claims costs incurred by an eligible carrier for a covered person's covered benefits, above which the claims costs for benefits are no longer eligible for reinsurance payments. A **"reinsurance payment"** is the amount paid to an eligible carrier under the program.

The bill grants the Commissioner of Insurance all of the powers necessary to implement the program. The Commissioner is specifically authorized to:

- Enter into contracts for the program
- Take legal action as necessary to avoid the payment of improper claims under the program
- Establish administrative and accounting procedures for the operation of the program
- Establish procedures and standards for carriers to submit claims under the program
- Establish or adjust the payment parameters for each benefit year
- Establish a fee schedule, setting the amount that providers will be reimbursed for services provided to covered persons whose claims costs for covered benefits in the benefit year exceed the attachment point and for which a carrier submits a claim for payments under the program
- Apply for a state innovation waiver, federal funds, or both, for the implementation and operation of the program
- Apply for, accept, administer, and expend gifts, grants, and donations, and any federal funds that may become available for the program
- Adopt rules as necessary

If the program is approved, during implementation the DOI is to evaluate the effect of the program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost sharing reductions and minimize any potential negative effects on those consumers. Within 120 days following the end of the second full year of operation of the program, the DOI is to complete a study of and issue a report on the effects of the program on access for those consumers. The report is to be posted on the DOI's website and be submitted to the Governor, Senate Health and Human Services Committee, and House Health and Insurance Committee.

The Colorado reinsurance program is created in the DOI to provide payments to eligible carriers. The implementation and operation of the program is contingent upon approval of the state innovation waiver or federal funding request. The program is an enterprise for the purposes of Taxpayer's Bill of Rights (TABOR) in the Colorado Constitution. The Commissioner, on behalf of the program, is authorized to issue revenue bonds for the expenses of the program, as subject to approval by the General Assembly and approval by the Governor. If the waiver application is approved by the federal government, the Commissioner is to implement and operate the program. The DOI is to collect or access data from each carrier to determine reinsurance payments. On a quarterly basis during the benefit year, each carrier is to report to the DOI the claims costs that exceed the attachment point for that benefit year and attest to the DOI that the carrier paid claims above the attachment point at the rates specified in the fee schedule. Each benefit year, the DOI is notify the carriers of the reinsurance payments to be made no later than June 30 of the year following that benefit year. By August 15 of the year following the benefit year, the DOI is disburse all reinsurance payments to each carrier.

To determine eligibility for and calculating payments under the program for the 2020 benefit year, the Commissioner shall set the payment parameters at amounts to achieve:

- A reduction in claims costs of 30-35 percent in geographic rating areas 5 (Grand Junction) and 9 (West)
- A reduction in claims costs of 20-25 percent in geographic rating areas 4 (Fort Collins), 6 (Greeley), 7 (Pueblo), and 8 (East)
- A reduction in claims costs of 15-20 percent in geographic rating areas 1 (Boulder), 2 (Colorado Springs), and 3 (Denver)

For the 2021 benefit year, and each benefit year thereafter, after a stakeholder process, the Commissioner is to establish and publish payment parameters by March 15, the year proceeding the applicable benefit year. In setting these payment parameters, the Commissioner is to consider the following factors in each geographic rating area in Colorado:

- Participation and competition by carriers in the individual market
- Enrollment across all income levels and morbidity in the individual market
- Participation and competition by providers
- Rates in the individual market

If the amount of money from specified funding sources (detailed further below) is anticipated to be inadequate to fully finance the payment parameters, the Commissioner is to establish new parameters within the available funding. The Commissioner is to allow a carrier to revise an applicable rate filing for the next benefit year based on the final established payment parameters and on actual reinsurance payments received by the eligible carrier.

An eligible carrier must make request for payments in accordance with requirements that are established by the Commissioner. By April 30 of the year following the applicable benefit year, in order to receive payments through the program the eligible carrier must:

- Provide the DOI with access to the data within a dedicated environment established by the carrier under the federal risk adjustment program
- Submit to the DOI an attestation that the carrier has complied with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines

The carrier is to maintain sufficient records to substantiate the requests for payments for at least six years. Those records should be available upon request by the DOI for purposes of verification, investigation, audit, or other review of payment requests. The Commissioner can have a carrier audited to assess their compliance with the requirements of the program. The carrier is to ensure that its contractors, subcontractors, and agents cooperate with any audit that is conducted.

The DOI is to calculate each payment based on the incurred claims costs for a covered person's covered benefits in that benefit year. If the claims costs do not exceed the attachment point for the benefit year, the carrier is not eligible for a reinsurance payment. If the claims costs do exceed the attachment point, the Commissioner is to calculate the payment as the product of the coinsurance rate and the claims costs, up until the limit of the reinsurance cap. If claims costs exceed the reinsurance cap, the carrier is ineligible for any payments for claims costs above that point. The Commissioner is to ensure that the payments to the carrier do not exceed the total amount paid by the carrier for any eligible claim. This total amount is the amount paid by the carrier based on the allowed amount less any deductible, coinsurance, or copayment. A carrier can request that the Commissioner reconsider a decision on its request for reinsurance payments within 30 days after notice of the Commissioner's decision. A final action or order of the Commissioner in regards to the decision is subject to judicial review.

In order to promote cost-effective health coverage and to be fair to federal taxpayers, the Commissioner through rulemaking, is to establish a fee schedule based on a percentage of Medicare reimbursement rates that, along with the federal pass-through funding, will reduce claims costs. The fee schedule must specify the reimbursement rate for a provider that provides services to a person whose claims costs for covered benefits in the benefit year exceed the attachment point and for which a carrier submits a claim for reinsurance payment. For claims that exceed the attachment point, carriers are to adjust payments to providers based on the fee schedule. The Commissioner may include in the fee schedule the reimbursement rate to be paid for any services not included in the schedule of Medicare reimbursement rates. The fee schedule is to be reviewed and adjusted annually. A provider, facility, emergency services provider, or other person providing services to a covered person for whom a carrier has submitted a claim for reinsurance payments shall not contract with or demand payment from the person or the program for amounts that exceed the applicable rate on the fee schedule. This does not prohibit providers and facilities from charging the covered person the applicable coinsurance, deductible, or copayment amounts. The fee schedule does not apply to primary care or behavioral health services. Through rulemaking, the Commissioner is to establish parameters for exempting hospitals that will be affected in an unsustainable way by the requirements of the fee schedule.

The DOI is to maintain an accounting for each benefit year of all the:

- Money appropriated for reinsurance payments and administrative/operational expenses
- Requests for payments received from carriers
- Payments made to carriers
- Administrative/operational expenses incurred for the program

By November 1 of the year following the applicable benefit year, or 60 days after the final disbursement of payments for that benefit year (whichever is alter), the Commissioner its make a report summarizing the program's operations for each benefit year public on the DOI's website. The program is subject to audit by the state auditor. On or before November 1, 2020, and each November 1 thereafter, the DOI is to include an update of the program in its annual SMART Act[30] Hearing.

The "reinsurance program cash fund" is established in the state treasury. It consists of federal pass-through funding and any other available federal funds. All money in the fund is continuously available to the DOI to be expended for the purposes of the program. The Commissioner may seek, accept, and expend gifts, grants, or donations from private or public sources for the program. All of these funds may be used for reinsurance payments and administrative/operating expenses.

In order to implement and operate the program for plan years starting on January 1, 2020, the Commissioner s to apply to the U.S. Secretary of Health and Human Services for a five-year Section 1332 state innovation waiver, federal funds for the program, or both. The application for the waiver for federal funds must clearly state that the operation of the program is contingent on approval of the request. The waiver application must adhere to the requirements outlined in Section 1332. The waiver is also to include a request for federal pass-through funds. If there is any federal action on the application, the Commissioner is to notify, in writing, the Joint Budget Committee, Senate Health and Human Services Committee, House Health and Insurance Committee, and House Public Health Care and Human Services Committee.

If there is an approval or denial of the application from the U.S. Secretary of Health and Human Services, the Commissioner is to notify the revisor of statutes in writing. If it is denied, this entire program is repealed in statute, effective the date of the denial. If it is approved, the program continues until September 1, 2024, when it is up for review to be repealed.

This bill is effective upon the Governor's signature.

[30] State Measurement for Accountable, Responsive, and Transparent Government Act

Reasons to Support

The program may provide relief to the 124,000 people who buy coverage on the individual market but do not receive the federal Advance Premium Tax Credits. A healthier market could ultimately have a positive effect on the amount of their premiums in the long-term. If prices in the individual market decrease, it could spur some of the uninsured to gain coverage. Most of those that are foregoing insurance are reporting that they are doing so due to cost. It is likely that the removal of the individual mandate from the federal government coupled with increasing costs for health insurance in the individual market will increase the amount of Coloradans that are uninsured. Addressing the cost of premiums in the individual market could keep these people in the market, which could avert uncompensated care costs associated with increased uninsurance rates. Although reinsurance does not solve the problem of affordability, it provides a better anticipated outcome than the status quo. Decreased premiums on the individual market would allow more individuals and families that do not qualify for subsidies to be able to afford health insurance while being able to pay for food and utilities, repay student loans, and/or contribute to retirement plans.

Reinsurance could also help keep carriers in the market as the program removes some of the financial risk from the entities. Keeping these carriers in the market improves competition in the market. Improved competition results in increased choice for consumers.

Setting a fee schedule would allow for predictability for insurers when providing coverage for those cases with high claims costs. Further, creating a uniform rate for these circumstances that applies throughout the state, except for those hospitals exempted through rulemaking, may mean less risk for insurers providing coverage in rural areas.

Supporters

- Anthem Blue Cross and Blue Shield
- Center for Health Progress
- Chronic Care Collaborative
- Colorado Center on Law and Policy
- Colorado Consumer Health Initiative
- Colorado Organizations Responding to AIDS
- Connect for Health Colorado
- Counties and Commissioners Acting Together (CCAT)
- Eagle County
- Healthier Colorado
- Multiple Sclerosis Society
- Summit County

Reasons to Oppose

Some assert that the bill allows the state and the Commissioner of Insurance to arbitrarily set rates, which may mean facilities and providers may face significant cuts with unintended consequences. Some may have to reduce services, cut staff, or increase costs for those with employer-sponsored insurance. Since the waiver application needs to be submitted to the federal government by mid-summer in order to have the program ready by plan year 2020, it will be difficult, some assert impossible, to set up a rate structure.

Opponents

- Colorado Chapter College of Emergency Physicians
- Colorado Hospital Association
- Colorado Medical Society[31]
- SCL Health

[31] In testimony at the House Health & Insurance Committee hearing, the representative from the Colorado Medical Society stated that the group was testifying in a neutral position to the bill but the Secretary of State's website lists the organization as opposing the bill.

Other Considerations

It is important to note that no other state has tried to fund the state portion of a reinsurance program through provider-rate setting; therefore, it is unknown if it is a strategy that would get approval from the federal government, or if it will be as successful as other programs. Some are concerned that the exemption criteria for hospitals affected in an unsustainable way by the requirements of the fee schedule are not outlined in the bill and are instead left to the DOI's rulemaking authority. The uncertainty greatly worries such facilities. The bill does not define "affected in an unsustainable way," which has proved concerning for many groups. Furthermore, the bill does not create an exemption for individual providers, or a provider group, that would be negatively affected in an unsustainable manner. An actuarial analysis on the proposal is expected sometime during the month of March. Without this analysis, many groups have asserted that it is impossible to know how the fee schedule will affect their operations as it is unknown at what benchmark of Medicare the state is considering setting rates. Furthermore, some procedures (i.e. pregnancy-related and pediatric services) are not reimbursed by Medicare so it is difficult for providers to predict the benchmark that the state will use for those services.

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 summary 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

3/8/2019

STAFF: ALYSON WILLIAMS POLICY MEMO

SB19-139: MORE COLORADO ROAD AND COMMUNITY SAFETY ACT OFFICES

Concerning the issuance by the department of revenue of identification documents to people who are note lawfully present in Colorado on a permanent basis, and in connection therewith, making an appropriation

Policy Issue Summary

The Community Road and Community Safety Act (SB13-251) passed the Colorado legislature in 2013. The act allowed up to six DMV offices to offer undocumented Colorado residents driver's licenses. The program was designed as a self-funded model as the licenses cost $79 per applicant. Since 2013, the General Assembly has cut the program's budget and used the funds generated from the license fees to fund other priorities. Therefore, the number of participating DMVs in the state has decreased from six to three. This budget cut for the program also included a directive that after the disbursement of 60,000 licenses the Grand Junction and Colorado Springs DMVs are to stop participating in the program. This cap of 60,000 licenses is expected to be reached in 2018, meaning the only participating DMV would be in Denver.

Another issue that has arisen from the original legislation is that the drafting of the bill erroneously excluded immigrants that have Social Security Numbers (SSNs). During the 2017 legislative session, HB17-1206 would have allowed SSNs (which were allowed for some people in the 1990s) to be used to meet the documentation requirement in addition to the current use of taxpayer identification numbers and to allow for licenses to be reissued or renewed with the same process as other licenses (i.e. online). That bill failed to pass, but the issue rose again during the 2018 session with SB18-208, which passed.

A statewide coalition called the iDrive Colorado Campaign formed to support the attempt to restore access to licenses for all undocumented Coloradans and expand access to the program.

Reason for Involvement by the Health District of Northern Larimer County

Involvement Background

The Health District was approached by staff from the Center for Health Progress (formerly known as the Colorado Coalition for the Medically Underserved) with a request to sign on as a supporter of the iDrive Colorado Campaign during the 2018 legislative session, which the Board supported. This year, staff have been contacted again to be supporters of the campaign and of legislation, SB19-139, which would require these driver's licenses be issued at 10 or more offices that are geographically distributed throughout the state.

Possible Points for Support

There are significant public health and safety benefits of providing Colorado's undocumented immigrants with a form of identification and the ability to drive legally. First, in order to receive a driver's license an individual must pass practical and written examinations, which improve a driver's safety on the road and protect other drivers. Research has demonstrated that California's similar policy in the year after implementation reduced the occurrence of hit and run accidents in the state.[1]

[1] Lueders, H., Hainmueller, J., & Lawrence, D. (2017). Providing driver's licenses to unauthorized immigrants in California improves traffic safety. *Proceedings of the National Academy of Sciences of the United States of America, 114* (16), 4111-4116. http://dx.doi.org/10.7910/DVN/NVRBC9

Second, access to transportation can impact the ability of individuals and their families to access health care and secure basic necessities. The 2017 Colorado Health Access Survey documented that challenges with transportation resulted in no care or delayed care for 5.5 percent of Coloradans.[2] Access to health care is not only important to the patient, but the community as a whole. When the patient has a communicable disease, stopping the spread of the illness is an urgent public health issue.

Third, without access to transportation there may be barriers to accessing healthy foods. There are four Census tracts in Larimer County that are designated food deserts by the U.S. Department of Agriculture.[3] These areas include low-income communities that lack ready access to healthy foods; therefore, many have to depend on transportation to access these foods.

The attached white paper entitled "Why providing drivers' licenses to immigrants is a public health and health care issue: The case for supporting the iDrive Colorado Campaign" provides further detail.

Possible Points for Opposition

Some might say that driver's licenses are a privilege and not a right to every person within the state. Furthermore, expanding this program could provide another incentive for undocumented immigrants to reside in Colorado. Some have raised concerns that providing licenses would allow these individuals to access public benefits or vote in elections; however, the Colorado program includes a clarifying phrase on the front of the license that makes them invalid for those purposes.[4]

Others fear that expanding the program would allow the licenses to clearly identify undocumented immigrants and deport them to their country of origin.

About this Memo

This memo 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 memo is not a complete analysis of this policy issue. This memo is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

[2] Colorado Health Institute (2017). *Colorado's New Normal: Findings from the 2017 Colorado Health Access Survey.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf.

[3] Economic Research Service, U.S. Department of Agriculture (March 2017). *Food Access Research Atlas.* Retrieved from https://www.ers.usda.gov/data/fooddesert. Accessed on January 15, 2018.

[4] The phrase states "not valid for federal identification, voting, or public benefit purposes"

WHY PROVIDING DRIVERS' LICENSES TO IMMIGRANTS IS A PUBLIC HEALTH & HEALTH CARE ISSUE: THE CASE FOR SUPPORTING THE I DRIVE COLORADO CAMPAIGN

Legislators should consider the significant public health benefits of providing Colorado's immigrants with a standard form of identification and the ability to drive legally.

In 2013, the Colorado state legislature passed SB 251, also known as The Colorado Road and Community Safety Act, which allowed up to six Colorado DMV offices to offer driver's licenses to immigrants without documentation residing in Colorado. The program was seen as a key step toward improving the safety of Coloradans on the road by allowing immigrants to take vision and road tests, obtain a license, and secure car insurance. Built on a self-funded model (licenses for these immigrants cost $79 per applicant, versus the $25 for other Colorado residents), the program was intended to place no additional burden on taxpayers.

Since the law passed, many of the 120,000 immigrants eligible for this program have been facing major difficulties in obtaining a driver's license, and an additional 60,000 are anticipated to become eligible due to the rescission of DACA and TPS (temporary protected status). The legislature cut the program's budget and used the license fees to fund other legislative priorities. As a result, the number of participating DMV offices across the state dropped from six to three, severely limiting the number of appointments available and forcing immigrants to travel long distances to apply for a license. The budgetary cut also included a directive that DMV offices in Grand Junction and Colorado Springs close once 60,000 total licenses in Colorado are granted, which was based on early estimates of eligibility. This cap is expected to be reached in 2018, meaning only one office would remain unless further action is taken, and this one office would be in Denver, which would especially limit access for immigrants located in rural areas of the state.

Additionally, a minor drafting error incurred major inefficiencies in the program by erroneously excluding some immigrants from this program, specifically immigrants who have a Social Security Number as granted in the 1990s. Before welfare reform at the federal level passed in 1996 (the 1996 Personal Responsibility and Work Opportunity Act), immigrants received valid Social Security Numbers. Additionally, there are some others who were granted temporary status through work visas. SB 18-108, if passed, would include this group of immigrants.

Last but not least, SB 18-108 would also enable qualifying applicants to renew their driver's licenses online as they are currently not allowed to do so. This will streamline the renewals

process, rather than increasing demand for appointments in already overwhelmed system limited to Aurora, Denver, Grand Junction, or Colorado Springs offices.

In an effort to address the myriad issues, the *I Drive Colorado* campaign was established to advocate for greater access to driver's licenses for immigrants without documentation, and to specifically for 2018, bring changes to the law through legislative and budgetary fixes. As the campaign supports SB 18-108 to improve upon SB 13-251, **legislators should consider the significant public health benefits of providing Colorado's immigrants with a standard form of identification and the ability to drive legally.**

WHY THIS MATTERS FOR HEALTH CARE

There is a strong connection between a person's access to reliable transportation and their ability to access health care when they need it. In the 2017 Colorado Health Access Survey, 309,650 Coloradans said they did not get the care they needed because they lacked transportation to the doctor's office or the doctor's office was too far away. While this number is not exclusively immigrants, challenges with transportation result in no care or delayed care, as well as worse health outcomes.

Without transportation, people delay care for themselves and family members, which could lead to worsening conditions, reliance on emergency transportation and emergency room use, and even death. When people are able to safely transport themselves and their family members to the doctor's office for routine check-ups or for more urgent needs, health care issues are addressed in a more timely manner and reliance on the 911 system is reduced. Despite the advances made in metro Denver and in the rest of the state in expanding public transportation infrastructure, the significant gaps leave people with little alternative but to rely on their own personal transportation.

Additionally, health care systems in Colorado have shared anecdotally that in an attempt to save money on emergency room costs and to increase more consistent access to care, they have had to build into their budgets support for non-emergent medical transportation for anyone who does not have a way to get to the doctor. If more Coloradans were able to access a driver's license and transport themselves, the cost to the system could be reduced.

WHY THIS MATTERS FOR PUBLIC HEALTH

Immigrants having access to driver's licenses has the potential for lasting impact on the health and safety of all Coloradans, which cannot be overstated. The social determinants of health help us understand that health is determined by the structural conditions in which people live, work, learn, play, grow and age. As a social determinant of health, transportation determines families' ability to access health care, secure basic necessities, and fully take part in the life of

their community. Colorado's immigrants help drive our economy and contribute to the rich fabric of our communities. Providing opportunity for immigrants to lead healthy and productive lives benefits us all. Allowing these Coloradans to obtain a driver's license is therefore an important step toward making Colorado a healthier state.

HEALTHY CHOICES ARE OUT OF REACH WITHOUT PERSONAL TRANSPORTATION

Beyond direct access to health care services, barriers to personal transportation can also affect a person's health in several other ways. Without freedom of movement, immigrants face unnecessary challenges in securing basic human needs, such as healthy foods, safe housing, good education opportunities for children, well-paying jobs, and more. Data shows that 40% of what contributes to an individual's health are social and economic factors, such as income, education, and community safety. Another 30% of an individual's health is determined by health behaviors, but our health behaviors are determined by the choices we have available to make. The lack of personal transportation makes a simple trip to the grocery store difficult, hindering one's ability to choose to purchase healthy food products. It can also force families to factor in the availability of nearby public transit options in deciding where to live. In turn, this might mean making sacrifices on the quality of housing -- and potentially being exposed to lead, mold, and unsafe structures -- or having to default to the neighborhood school, regardless of quality. Lacking any of these necessities could contribute to worse health outcomes for immigrants and higher health care costs overall.

DRIVER'S LICENSES TO PROTECT IMMIGRANTS AND THE PUBLIC

To get a driver's license, people must first pass required examinations, such as traffic law and road sign tests and vision examinations. These requirements improve safety on the road and protect other drivers. Obtaining a driver's license also makes it easier to acquire automobile insurance, which has been linked to safer driving conditions overall. Multiple studies indicate a correlation between uninsured drivers and fatal automobile accidents. Studies also indicate that if more motorists are insured in the state, automobile insurance costs would likely decrease across the board, freeing up resources for other life necessities. Specifically in California, which passed AB 60 in 2013, granting licenses to 600,000 immigrants saw a reduction in hit-and-run by 4,000 or 10%. They also saw a savings of $3.5 million in out-of-pocket expenses as well.

IMMIGRANTS WITH DRIVER'S LICENSES PARTICIPATE IN COMMUNITIES

Fear of deportation breeds mistrust of our hardworking law enforcement agencies and is a major barrier to immigrants' ability to engage with institutions and their communities. For example, police departments in several large cities across the US are seeing a decline in reporting of sexual assault and domestic violence among Latinos, where among non-Latinos, reporting has remained either unchanged or has risen. Specifically, in Denver in 2017, Latinos reporting crimes dropped 12% while among non-Latinos, reporting had arisen 36%. In Houston, they saw a 42% decrease in Latino victims reporting rape, and in Los Angeles, they saw a 25%

decline in sexual assault reports and 10% decline in domestic violence reports. While not all Latinos are immigrants, this is a proxy for understanding changed behaviors among immigrants. From anecdotes, the reason behind this is heightened fear of deportation, which decreases safety among immigrant communities as well as their ability to trust critical institutions.

Because the original bill explicitly bans law enforcement from using these driver's licenses for deportation purposes, immigrants can drive without the fear that driving-related infractions could result in their deportation or their family's. As a standard piece of identification, driver's licenses help facilitate immigrants' interactions with businesses, government agencies, and the community at large. The resulting sense of safety and belonging is critical to any individual's social and professional trajectory.

Immigrants who can safely travel from their home to their place of work (or while on the job) may also have more options for employment, which would both help their families' financial stability and improve Colorado's health systems and economy. Home health workers, for example, are critical assets to the health care industry caring for people in their homes, and the ability to drive from one patient's home to the next is critically important.

SUPPORTING THE *I DRIVE COLORADO* CAMPAIGN

Based on the demonstrated public health benefits of enabling immigrants without documentation to qualify for Colorado driver's licenses, the following organizations express our full support for the *I Drive Colorado* campaign and its objectives to:

- Address the DMV appointment cap
- Allow for online renewals of current license-holders
- Enable individuals with taxpayer identification numbers or Social Security numbers to qualify for the program

Senators Larry Crowder and Don Coram are sponsoring Senate Bill 18-108 to advance the latter two priorities of the campaign; Representatives Jonathan Singer and Jeni Arndt are sponsoring this in the House.

Achieving these objectives will be paramount to safeguarding and improving Colorado's public health. Signatories of this white paper are committed to working with the *I Drive Colorado* campaign, along with state and local leaders, community members, advocates, and health care providers to improve the health of all Coloradans.

Health and health equity organizations endorsing the campaign include, but are not limited to:
Center for Health Progress (formerly Colorado Coalition for the Medically Underserved)
American Academy of Pediatrics - Colorado Chapter

Asian Pacific Development Center
Clinica Tepeyac
Clinica Colorado
Colorado Behavioral Healthcare Council
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Children's Immunization Coalition
Colorado Community Health Network
Colorado's Community Safety Net Clinics
Colorado Consumer Health Initiative
Colorado Cross Disability Coalition
Colorado Fiscal Institute
Colorado Public Health Association
CREA Results
DAWN Clinic
Denver Health
DRIVE Project
Full Circle of Lake County, Inc.
Health District of Northern Larimer County
Kids First Health Care
Metro Community Provider Network
Mountain Family Health Centers
One Colorado Education Fund
Oral Health Colorado
Padres y Jovenes Unidos
Pueblo Triple Aim Coalition
Rocky Mountain Youth Clinics
Tri-County Health Network
United For A New Economy (formerly FRESC: Good Jobs, Strong Communities)
Young Invincibles

The I Drive Colorado campaign is led by:
Together Colorado
Colorado Immigrant Rights Coalition
Mi Familia Vota
Colorado People's Alliance
American Friends Service Committee

Contact the communications lead of the campaign, Cristian Solano-Córdova (Cristian@coloradoimmigrant.org) for the full list of endorsing organizations as well as additional

detail about the campaign. For more on the health perspective, contact Aubrey Hill (aubrey.hill@centerforhealthprogress.org).

SOURCES

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Pew Charitable Trusts
American Immigration Council
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ACLU Ohio
New York Times
The Atlantic
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Centers for Disease Control and Prevention
County Health Rankings
Newsweek

Health District
OF NORTHERN LARIMER COUNTY

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: March 8, 2019

Re: Staff Recommendation on SB19—139: More Colorado Road & Community Safety Act Offices

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The Health District Public Policy Strategy Team recommends the Board of Directors sign on again as a supporter of the iDrive Campaign and support SB19-139.

Health District
OF NORTHERN LARIMER COUNTY

3/8/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1131: PRESCRIPTION DRUG COST EDUCATION

Concerning a requirement to share the wholesale acquisition cost of a drug when sharing information concerning the drug with another party.

Details

Bill Sponsors:	House – *Jaquez Lewis (D)* Senate – *Winter (D)*
Committee:	House Health & Insurance Senate Health & Human Services
Bill History:	1/25/2019- Introduced- Assigned to House Health & Insurance 2/20/2019- House Health & Insurance Refer Amended to House Committee of the Whole 3/1/2019- Second Reading in House- Passed with Amendments 3/4/2019- Third Reading in House- Passed 3/7/2019- Introduced in Senate- Assigned to Health & Human Services
Next Action:	Hearing in Senate Health & Human Services
Fiscal Note:	2/13/2019 Version

Bill Summary

The bill requires a drug manufacturer or their representative to provide in writing the wholesale acquisition cost of a prescription drug to a prescriber when they are sharing other information about that drug. Also, the bill requires the manufacturer or their representative to provide the names and wholesale acquisition costs of at least three generic drugs from the same therapeutic class as the prescription drug.

Issue Summary

Wholesale Acquisition Cost

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.[1] 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."[2] The WAC serves as a basis for negotiations between entities in the supply chain.

Marketing Drug Products to Prescribers

"Detailing" is a marketing approach that relies on face-to-face promotional activities that are directed to prescribers and pharmacy directors.[3] This typically includes a visit from the manufacturer's representative to the prescriber to pitch a specific product.

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[1] Meador, M. Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry through Regulation.
[2] 42 USC § 1395w-3a(c)(6)(B)
[3] Pew Trusts (Nov. 11, 2013). *Persuading the Prescribers: Pharmaceutical Industry Marketing and its Influence on Physicians and Patients.* Retrieved from https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2013/11/11/persuading-the-prescribers-pharmaceutical-industry-marketing-and-its-influence-on-physicians-and-patients

Role of Prescribers

Of respondents from organizations (i.e. executives, clinical leaders, and physicians) that are directly involved in health care delivery, 72 percent said that the out-of-pocket cost for the patient enters into clinical decisions at their organization.[4] However, 86 percent agreed that physicians are not trained to discuss the cost of care. Another study has found that giving formulary and drug cost information to providers was associated with lower increases in total drug costs, but not with increased adherence or decreases in out-of-pocket costs.[5] When teaching hospitals put restrictions on the activities of pharmaceutical sales representatives in their facilities, the doctors within those hospitals tended to order fewer promoted brand-name drugs and used more generic versions instead.[6]

This Legislation

When a manufacturer or the representative, agent, or employee of a manufacturer, who, while employed by or under contract to represent the manufacturer, engages in prescription drug marketing, they are to provide a prescriber, in writing, the WAC of a prescription drug when providing other information concerning the drug to the prescriber. When providing this information, the manufacturer or their representative is to also disseminate the names and WACs of at least three generic drugs from the same therapeutic class. If three are not available, they are to provide as many as are available for prescriptive use.

In this bill, a "prescriber" is defined as a health care provider that is licensed by the state and authorized to prescribe controlled substances or prescription drugs. "Prescription drug marketing" is defined as any activity that may include in-person meetings, physical mailings, telephone conversations, video conferencing, e-mails, texting, or faxes that provide educational or marketing information or materials regarding a prescription drug. The bill defines a "therapeutic class" as a group of similar drugs that have the same or similar mechanisms of action and are used to treat a specific condition.

The entirety of this language is repeated in a second section that only takes effect on October 1, 2019, only if HB19-1172, which proposes to recodify and reorganize Title 12 of the Colorado Revised Statutes, is passed and signed into law. The first section of the bill is included in case HB19-1172 does not pass.

Fiscal Note

Legislative Council Staff asserts that this bill will require a minimal increase in workload for the State Board of Pharmacy to perform rulemaking, which can occur within existing appropriations.

Reasons to Support

Prescribers can compare the brand-name drug WAC to therapeutically similar generics to determine if a lower cost generic may be more appropriate to prescribe to their patient(s). This may give prescribers a tool for considering cost and possible affordable alternatives while prescribing drug products.

Supporters

- AARP
- America's Health Insurance Plans
- Boulder County
- Center for Health Progress
- Colorado Association of Health Plans
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Foundation for Universal Health Care

[4] University of Utah (July 2018). Buzz Survey Report: Cost of Care and Physician Responsibility. *NEJM Catalyst.* Retrieved from https://catalyst.nejm.org/buzz-survey-university-of-utah-health-1-cost-care/

[5] Tseng, C., et al. (Sept. 2016). Giving formulary and drug cost information to providers and impact on medication cost and use: a longitudinal non-randomize study. *BMC Health Serv Res, 499*(16). DOI: 10.1186/s12913-016-1752-4

[6] Larkin I, Ang D, Steinhart J, et al. Association Between Academic Medical Center Pharmaceutical Detailing Policies and Physician Prescribing. JAMA. 2017;317(17):1785–1795. doi:10.1001/jama.2017.4039

- Colorado Medical Society
- Colorado Pharmacists Society
- RxPlus Pharmacies

Reasons to Oppose

The contracts between manufacturers and wholesalers and between wholesalers and pharmacies tie payment to WAC, but negotiated rebates frequently lower the actual price of a drug substantially below WAC. Negotiated rebates vary significantly by product, as well as by health plan or pharmacy. For example, a plan's formulary may consist of four tiers: preferred generics (tier 1), preferred brands (tier 2), non-preferred brands and generics (tier 3), and specialty (tier 4). A drug on a higher tier typically has a higher cost-sharing requirement for the consumer. Under this proposal, a prescriber may choose a therapeutically similar generic that was noted by a manufacturer representative because the WAC was lower than the WAC for the brand-name drug. However, under the patient's health plan the brand-name drug is on tier 2 while that particular generic is a non-preferred drug on the formulary and placed on tier 3. That could mean the patient ends up paying more for that generic than they would have for the brand-name drug.

Opponents

- Astellas Pharma
- Bayer
- Bristol-Myers Squibb
- Colorado Bioscience Association
- Colorado Chamber of Commerce
- Gilead Sciences
- Merck
- Novartis
- Otsuka America Pharmaceuticals
- Pfizer
- Pharmaceutical Research Manufacturers of America (PhRMA)
- Sanofi

Other Considerations

It is important to note that many provider groups and health systems do not allow for manufacturers or their representatives to detail their employees; in September 2013, the Federal Physician Payment Sunshine Act went into full effect. The transparency requirements of the Act prompted physician practices and hospitals to severely restrict pharmaceutical representatives' direct access to their physicians. Therefore, there are large amounts of providers that would not be getting the information regarding the WAC of a brand-name drug or therapeutically similar generics. They may still get marketing information through mailings, e-mails, faxes, but the extent of this indirect education is unknown.

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 summary 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

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: March 8, 2019

Re: Staff Recommendation on HB19-1131: Prescription Drug Cost Education

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The Health District Public Policy Strategy Team recommends the Board of Directors remain neutral on HB19-1131. The intent of the bill is admirable, but due to the complexity of how prescription drugs are priced, it is difficult to find a reliable method for prescribers to know what the actual cost to the consumer will be.

Health District
OF NORTHERN LARIMER COUNTY

3/8/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1120: YOUTH MENTAL HEALTH EDUCATION AND SUICIDE PREVENTION

Concerning multiple approaches to prevent youth suicide.

Details

Bill Sponsors:	House – *Michaelson-Jenet (D) and Roberts (D)* Senate – *Fenberg (D) and Coram (R)*
Committee:	House Public Health Care & Human Services House Appropriations
Bill History:	1/16/2019- Introduced 2/20/2019- Hearing in House Public Health Care & Human Services- No Action Taken 3/1/2019- House Public Health Care & Human Services Refer Amended to House Appropriations
Next Action:	Hearing in House Appropriations
Fiscal Note:	2/1/2019 Version

Bill Summary

A mental health professional may provide psychotherapy services to a minor that is 12 years old or older with or without the consent of the parent or guardian if the professional determines that the minor is knowingly and voluntarily seeking the services and the provision of the services is clinically indicated and necessary to the minor's wellbeing. The Department of Education is to create and maintain a resource bank of evidence-based, research-based, and promising program materials and curricula on mental health to be used in elementary and secondary schools in the state.

Issue Summary

Youth Mental Health in Colorado

In 2015, Colorado ranked ninth for the highest suicide rate in the United States and is consistently among the top ten states with the highest suicide rates nationally.[1] Among youth and young adults ages 10 to 24, suicide remained the leading cause of death in Colorado[1]. In 2016, 83 people completed suicide in Larimer County.[3] Of these 83 cases, 4 were under the age of 18, with the youngest being 15 years of age.[2]

The 2017 Healthy Kids Colorado Survey had a variety of findings on the mental health of high school students.[3] In Larimer County, 19.9 percent of students reported purposefully hurting themselves without wanting to die in the past 12 months, higher than the state average of 17.8 percent. Approximately 17 percent of Colorado high school students, and 44.8 percent of students that identified as gay, lesbian or bisexual, reported seriously considering attempting suicide in the past 12 months. Also, 7 percent of Colorado high school students reported attempting suicide in the past 12 months.

[1] Brummett, S., Fine, E., Hindman, J., & Myers, L. (2017). *Office of Suicide Prevention Annual Report 2016-2017*. Department of Public Health and Environment. Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf
[2] Wilkerson, J. (2017). *2016 Annual Report*. Loveland: Office of the Larimer Counter Coroner. Retrieved from https://www.larimer.org/sites/default/files/uploads/2017/2016-annual-report.pdf
[3] CDPHE (2018). *2017 Healthy Kids Colorado Survey Results.* Retrieved from https://drive.google.com/file/d/1rdCj0UbeF9VK8793FtNlPIAL6i4UwzQ5/view

Age of Consent

Currently, minors in Colorado must be 15 years of age or older to consent, without the permission of a parent or legal guardian, to receive mental health services rendered by a facility or professional mental health provider.[4] As of 2015, approximately 34 states found minor consent to be sufficient for receiving outpatient mental health services; however, the age varies by state. Of those 34 states, only California[5][6], Illinois, and Georgia have an age of consent at 12 years of age.[7]

According to Kerwin et al. (2015), "adolescents might be discouraged from seeking help for personal problems if parents were told about the adolescent's concerns and behaviors. Furthermore, it was thought that giving minors more control over their health care decisions might enhance their response to treatment. As a result, many states began to accord minors limited autonomy to provide consent for treatment of sensitive and private issues, such as pregnancy, sexually transmitted diseases, and drug, alcohol or mental health problems."

Youth Mental Health Resources

There are reliable resources that are available on the internet in regards to youth mental health and suicide. The main resource is the Suicide Prevention Resource Center (SPRC), which is a federally supported resource center that is dedicated to advancing the implementation of the National Strategy for Suicide Prevention.[8] Among other actions, the SPRC provides consultation, training, and resources to enhance suicide prevention efforts for states, educational settings, and other groups or locations.

Training Programs

According to the Suicide Prevention Resource Center (SPRC), there are few evidence-based youth suicide prevention programs currently in the U.S.[9] Both *Kognito At-Risk for High School Educators*[10] and *Lifelines Curriculum*[11] provide access to training programs for high school staff in order to act as gatekeepers by recognizing at-risk youth. *Sources of Strength* is a program that trains peer leaders to conduct well-defined messaging activities that aim to change peer group norms influencing coping practices and problem behaviors (i.e. self-harm, drug use, unhealthy sexual practices).[12]

In Larimer County, The Alliance for Suicide Prevention of Larimer County offers a *Hope for Today* training for community members to understand suicide, suicide prevention methods, and other mental health topics. [13] The Alliance also provides school-based suicide education and prevention programs in the Thompson School District and Poudre School District. The Health District of Northern Larimer County conducts the CAYAC

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[4] Voluntary applications for mental health services - treatment of minors, CO Rev Stat § 27-65-103 (2016)

[5] The bill that lowered the age of consent to 12 in California was supported by Equality California, the National Association of Social Workers California Chapter, Mental Health America of Northern California, and the Gay Straight Alliance Network (New CA Minor Consent Law Increases Teens' Access to Mental Health Care.

[6] National Center for Youth Law. (2010). New CA Minor Consent Law Increases Teens' Access to Mental Health Care. Retrieved from https://youthlaw.org/publication/new-ca-minor-consent-law-increases-teens-access-to-mental-health-care/)

[7] Kerwin, M. E., Kirby, K. C., Speziali, D., Duggan, M., Mellitz, C., Versek, B., & McNamara, A. (2015). What can parents do? A review of state laws regarding decision making for adolescent drug abuse and mental health treatment. *Journal of child & adolescent substance abuse*, *24*(3), 166-176. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4393016/

[8] Suicide Prevention Resource Center (2018). *About SPRC.* Retrieved from https://www.sprc.org/about-sprc

[9] Suicide Prevention Resource Center. (2018). *Resources and Programs*. Retrieved from https://www.sprc.org/resources-programs?type=All&program_evidence%5B%5D=1&populations=141&settings=All&problem=All&planning=All&strategies=All&state=All

[10] Suicide Prevention Resource Center.(2012). *Kognito At-Risk for High School Educators*. Retrieved from https://www.sprc.org/resources-programs/kognito-risk-high-school-educators

[11] Suicide Prevention Resource Center. (2009) *Lifelines Curriculum.* Retrieved from https://www.sprc.org/resources-programs/lifelines-curriculum

[12] Suicide Prevention Resource Center. (2011).*Sources of Strength.* Retrieved from https://www.sprc.org/resources-programs/sources-strength

[13] The Alliance for Suicide Prevention of Larimer County. *Hope for Today*. Retrieved from http://allianceforsuicideprevention.org/education-programs/hope-for-today/

(Child, Adolescent and Young Adult Connections) program, which conducts community education like Youth Mental Health First Aid Training.

Legislative History

Similar bills, HB17-1320 and HB18-1177[14], have been introduced in the previous two sessions to decrease the mental health consent age for outpatient care. Both passed the House and were postponed indefinitely by the Senate Committee on State, Veterans, & Military Affairs.

This Legislation

In the proposed legislative declaration, the General Assembly finds that the Centers for Disease Control and Prevention (CDC) found that in 2017 suicide is the 10th leading cause of death for all ages and the leading cause of deaths for you 10-14 years old. The Colorado Health Institute has found that Colorado has the 10th highest suicide rate in the country and that rates have doubled from 2016 to 2017 in the eastern plans of the state.[15] According to the National Institute of Mental Health, 21.4 percent of youth ages 8-15 experience a severe mental health disorder. According to the American Association of Suicidology, over the past three decades, the suicide rate for youth ages 10-14 has increased by more than 50 percent. Youth ages 10-14 often avoid obtaining, or are legally unable to obtain without parental consent, outpatient psychotherapy services that would help prior to reaching crisis levels. The proposed declaration continues by stating that the General Assembly declares that it is a matter of statewide concern to allow youth over the age of 12 to have legal access to outpatient psychotherapy services that might otherwise be unavailable without consent or notice to a parent or guardian. Providing this access is intended to reduce youth suicides and allow registered psychotherapists and licensed social workers to work with youth teach functional coping skills. Mental health professionals would have the opportunity to help youth build healthy connections with parents and guardians by increasing communication and strengthening the bond between the two, building an ongoing nonclinical support system for youth to use.

Psychotherapy or psychotherapy services are defined as the treatment, diagnosis, testing, assessment, or counseling in a professional relationship to assist individuals or groups to: alleviate behavioral and mental health disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors that interfere with effective emotional, social or intellectual functioning. Psychotherapy follows a planned procedure of intervention that takes place on a regular basis, over a period of time, or in the cases of testing, assessment, and brief psychotherapy, it can be a single intervention. The entirety of this language is repeated in a second section that only takes effect on October 1, 2019, only if HB19-1172, which proposes to recodify and reorganize Title 12 of the Colorado Revised Statutes, is passed and signed into law.

The bill defines a "mental health professional" as those licensed to practice medicine[16], psychologists, licensed social workers, licensed clinical social workers, licensed professional counselors, marriage and family therapists, addiction counselors, and school social workers[17]. A mental health professional may provide psychotherapy services to a minor that is 12 years old or older with or without the consent of the parent or guardian if the professional determines that the minor is knowingly and voluntarily seeking the services and the provision of the services is clinically indicated and necessary to the minor's wellbeing. The mental health professional may notify the youth's parent or guardian of the services given or needed with the youth's consent or the consent of the court-ordered individual that holds their therapeutic privilege,

[14] The Board of Directors supported concepts within the bill but remained neutral on lowering the mental health consent age.

[15] In 2017, the suicide rate in Health Statistics Region 1 (Morgan, Logan, Washington, Sedgwick, Phillips, and Yuma) was 22.5 per 100,000 people and in HSR Region 5 (Elbert, Lincoln, Kit Carson, and Cheyenne) was 28.7 per 100,000 people. Retrieved from https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high

[16] C.R.S. 27-65-102 (17)

[17] School social workers are licensed by the Department of Education

unless notifying the parent or guardian would be inappropriate or detrimental to their care and treatment. The professional is to engage the child in a discussion about the importance of involving and notifying their parent or guardian and encourage that notification to support their care and treatment. The professional can notify the parent or guardian of the services given or needed if in their opinion, the youth is unable to manage their care or treatment. The professional is to document their attempts to notify the parent or guardian, whether the attempts were successful, or why they believe it would be inappropriate to contact the parent or guardian. This documentation is to be included in the clinical record, along with a statement signed by the youth that indicates that they are voluntarily seeking services. Services are to be provided in a culturally appropriate manner. Written and oral instructions, training of staff, and the provision of the services must be culturally appropriate and provided in a manner and format to support individuals that have limited English proficiency or a disability, and that respects diverse backgrounds (including different cultural origins, sexual orientation, or gender identity). These psychotherapy services do not include inpatient services and psychotropic medications cannot be prescribed to a youth who is under the age of 14. If the youth communicates a clear and imminent intent or threat to inflict serious bodily harm on themselves or others, mandatory reporting laws apply.[18] The entirety of this language is repeated in a second section that only takes effect on October 1, 2019, only if HB19-1172, which proposes to recodify and reorganize Title 12 of the Colorado Revised Statutes, is passed and signed into law.

The Department of Education, with assistance from the Office of Suicide Prevention, the Colorado Youth Advisory Council, and the Suicide Prevention Commission, is to create and maintain a resource bank of evidence-based, research-based, and promising program materials and curricula on mental health to be used in elementary and secondary schools in the state. The content of the resource bank must be youth friendly, culturally sensitive, and available in English and Spanish. The Department of Education can provide internet links to resources and materials pertaining to mental health available from other entities that they determine to be reliable. The Department is to solicit the input from youth, community mental health professionals, and school professionals. If there are available appropriations, the Department is to solicit requests for information and can contract for the organization and enhancement of the resource bank, development of mental health curricula for schools and providing the schools with the curricula, and training for educators and school staff on mental health. On and after July 1, 2020, the Department is to make the resource bank available for free to school districts, charter schools, institute charter schools, boards of cooperative services, professional educators, parents and guardians, students, and community providers. At the request of a school district, charter school, institute charter school, or board of cooperative services, the Department is to provide technical assistance in designing age-appropriate curricula pertaining to mental health. All of the materials and resources available in the bank must be developed and updated with youth input.

On or before July 1, 2020 the State Board of Education is to adopt standards that identify the knowledge and skills that an elementary through secondary education student should acquire related to mental health, including suicide prevention. When adopting standards, the Board is to take into account what local education providers are currently teaching in regards to mental health.

Except for the certain circumstances noted previously, the remainder of the bill is effective upon the Governor's signature.

Fiscal Note

The bill will increase state General Fund expenditures by $130,273 and 0.9 FTE in FY 2019-20 and $55,389 and 0.6 FTE in FY 2020-21 and future years for the Department of Education. This includes contractor costs

[18] C.R.S. 13-21-117(2)

to assist in preparing resources and facilitating the use of the resource bank in schools, stakeholder meetings to implement the resource bank, and staff work to develop, assemble and implement the resource bank.

Reasons to Support

Decreasing the age of consent could provide greater access to mental health services for communities such as homeless youth or LGBTQ youth whose parents do not condone mental health services or would refuse consent, youth who are embarrassed or ashamed of their need for mental health services/do not want to worry or disappoint their parents, or youth who are afraid of alienation or physical violence from their parents in response to their particular situation. The Gay Straight Alliance has particularly pushed for greater access to mental health services among youth as they may not feel ready or able to open up to their parents. This may be an effective way to get adolescents identifying as LGBTQ access to mental health services and may help to reduce the high number who consider suicide.

Supporters

- American Federation of Teachers-Colorado
- The Arc of Colorado
- Boulder County
- The Bridge Project
- Colorado Coalition Against Sexual Violence
- Colorado Counseling Association
- Colorado Cross-Disability Coalition
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Colorado Rural Health Center
- Denver Health
- Interfaith Alliance
- Mental Health Colorado
- NARAL Pro-Choice Colorado
- National Alliance on Mental Illness
- National Association of Social Workers, Colorado Chapter
- Project We Care Colorado
- Suicide Prevention Coalition of Colorado
- Violence Free Colorado
- Western Colorado Congress

Reasons to Oppose

Opponents of lowering the age of consent to 12 for outpatient care point towards the cognitive abilities of an adolescent to make decisions affecting their long-term welfare, as well as parents' rights to help find the best source of care for their child. Some assert that they have the right to be aware if their child is suffering from mental health issues. Furthermore, they have the right to choose the best course of action including types of services received or which provider the child sees.

Additionally, the mental health professional that is providing services to the youth can, in some cases, advise the parent/guardian about the services that have been given or are needed with or without the consent of the minor. This could cause confusion to the minor about the confidentiality of their time with a mental health provider. Another cause for confusion is that the age of inpatient treatment has remained at 15 years, which could make it more difficult to explain or understand when a child can access different types of care without parental consent.

Not all of the providers included in the "mental health professional" definition of the bill have the training and quality of care and those providing services to youth may vary widely. For example, addiction counselors do not always have mental health training necessary to provide appropriate care. Certified addiction counselors do not have the same requirements from the state as licensed addiction counselors. Licensed addiction counselors must be at least 21 years old, have completed a masters or doctorate degree in behavioral health sciences, demonstrated professional competence, completed hours of addiction-specific

training and completed 5,000 hours of clinically supervised work experience.[19] Whereas, there are three levels of certified addiction counselors (CACs), each requiring different amounts of clinically supervised work. The CAC-I level individual must be at least 18 years old, pass a criminal background check, and 1000 hours of clinical supervision. CAC-II and CAC-III level professionals require longer clinically supervised work experience, passage of a national exam, and experience in certain topics. It is important to note that only CAC-III requires the individual to possess a Bachelor's degree in behavioral science.

Opponents

- Christian Home Educators of Colorado
- Colorado Christian University
- Colorado Family Action

Other Considerations

This bill does not take into account neither how the minor will pay for services without notifying their parent or guardian nor how billing to insurance may inadvertently notify the parent or guardian.

This bill does not require educators and school staff to participate in training programs so it is questionable as to how many schools would put on trainings. The SPRC states that, "family members, friends, teachers, coaches, coworkers, and others can play an important role in recognizing when someone is at risk or in crisis and then connecting that person with the most appropriate sources of care. But these individuals may need training on how to identify suicide risk and provide assistance."[20] However, this bill would only provide training for educators and school staff on mental health and only subject to available appropriations.

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

[19] C.R.S. 12-43-804

[20] Identify and Assist Persons at Risk. (2018). Retrieved from https://www.sprc.org/comprehensive-approach/identify-assist

Health District
OF NORTHERN LARIMER COUNTY

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: March 8, 2019

Re: Staff Recommendation on HB19-1120: Youth Mental Health Education & Suicide Prevention

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The Health District Public Policy Strategy Team recommends the Board of Directors remain neutral on HB19-1120.

Health District
OF NORTHERN LARIMER COUNTY

3/8/2019

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB19-1009: SUBSTANCE USE DISORDERS RECOVERY

Concerning supports for persons recovering from substance use disorders, and, in connection therewith, expanding a program in the department of local affairs that provides vouchers for housing assistance to certain individuals, requiring each recovery residence operating in Colorado to be licensed by the department of public health and environment, and creating the opioid crisis recovery fund

Details

Bill Sponsors:	House – *Kennedy (D) and Singer (D)* Senate – *Priola (R),* Pettersen (D)
Committees:	House Public Health Care & Human Services House Appropriations Committee
Bill History:	1/4/2019- Introduced in House 3/6/2019- House Public Health Care & Human Services Refer Amended to Appropriations
Next Action:	Hearing in House Appropriations Committee
Fiscal Note:	2/1/2019 Version

Bill Summary

This bill expands an existing housing voucher program within the Department of Local Affairs (DOLA) to include individuals with a substance use disorder (SUD) and those in certain circumstances while appropriating an additional $4.3 million annually for the following 5 state fiscal years. Recovery residences that operate in Colorado would be required to be accredited by Colorado Association of Recovery Residences, chartered by Oxford House, or have operated as a recovery residence in the state for 30 or more years. The bill also creates the "opioid crisis recovery funds advisory committee" in order to advise and collaborate with the Department of Law on the uses of any funds received by the state as a result of opioid-related litigation.

Issue Summary

Housing First

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness. The approach is guided by the principle that an individual needs a basic necessity like housing before they can address other issues like a substance use disorder, obtaining a job, or learning how to budget.[1] The housing in this approach is intended to be permanent but the types of housing provided varies by program. Services that are provided include screening, needs assessment, housing assistance, support services, case management, and sometimes on-site medical or behavioral health care.[2] In this approach SUD services are usually offered, although abstinence and/or treatment are not required for participation.

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

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

A study found that individuals with SUD report less housing stability that those without a SUD. It further found that participants in the Housing First group were 17 times more likely than those in a "treatment as usual" group to report sustained housing and high scores on community functioning.[3] It is important to note that all types of SUDs do not respond the same to the Housing First model; one study has shown that stimulant users, such as cocaine, have somewhat less successful housing outcomes than individuals with other SUDs.[4]

What Are Recovery Residences?

The definition of recovery residences or recovery housing varies depending on the source. For example, the U.S. Government Accountability Office (GAO) described recovery housing as, "peer-run or peer-managed drug and alcohol-free supportive housing for individuals in recovery from substance use disorder."[5] Whereas the National Council for Behavioral Health broadly defines recovery housing as "safe, healthy, and substance-free living environments that support individuals in recovery from addiction."[6] Also, the National Association of Recovery Residences (NARR) has created a table that depicts the distinct levels of recovery support that are recognized in their standard.[7]

NARR National Association of Recovery Residences		RECOVERY RESIDENCE LEVELS OF SUPPORT			
		LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider
STANDARDS CRITERIA	ADMINISTRATION	• Democratically run • Manual or P& P	• House manager or senior resident • Policy and Procedures	• Organizational hierarchy • Administrative oversight for service providers • Policy and Procedures • Licensing varies from state to state	• Overseen organizational hierarchy • Clinical and administrative supervision • Policy and Procedures • Licensing varies from state to state
	SERVICES	• Drug Screening • House meetings • Self help meetings encouraged	• House rules provide structure • Peer run groups • Drug Screening • House meetings • Involvement in self help and/or treatment services	• Life skill development emphasis • Clinical services utilized in outside community • Service hours provided in house	• Clinical services and programming are provided in house • Life skill development
	RESIDENCE	• Generally single family residences	• Primarily single family residences • Possibly apartments or other dwelling types	• Varies – all types of residential settings	• All types – often a step down phase within care continuum of a treatment center • May be a more institutional in environment
	STAFF	• No paid positions within the residence • Perhaps an overseeing officer	• At least 1 compensated position	• Facility manager • Certified staff or case managers	• Credentialed staff

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

[4] Edens, E.L., Tsai, J., & Rosenheck, R.A. (2014). Does stimulant use impair housing outcomes in low-demand supportive housing for chronically homeless adults?. *Am J Addict*, *23*(3), 243-248. doi: 10.1111/j.1521-0391.2014.12089.x.

[5] U.S. Government Accountability Office (March 2018). *Information on Recovery Housing Prevalence, Selected States' Oversight, and Funding.* Retrieved from https://www.gao.gov/assets/700/690831.pdf

[6] National Council for Behavioral Health (May 2017). *Recovery Housing Issue Brief: Information for State Policymakers.* Retrieved from https://narronline.org/wp-content/uploads/2017/09/Recovery-Housing-Issue-Brief_May-2017.pdf

[7] NARR (2016). *Recovery Residence Level of Support.* Retrieved from https://narronline.org/wp-content/uploads/2016/12/NARR_levels_summary.pdf

NARR has created ethical and quality standards for operating residences at each of the four levels. The origins and operations of recovery residences are largely based on the principles of Alcoholics Anonymous and the vast majority have some level of participation in 12-step recovery groups.[8]

Recovery Residences in Colorado

Due to the fact that the state, or any other level of government, does not regulate or license recovery residences operating in Colorado, it is unknown how many businesses and residences exist in the state. Anecdotally it is known that recovery residences have been propagating throughout Colorado cities and towns. These homes frequently are group homes rather than treatment and recovery residences. It has been difficult for local governments to address their concerns with these homes due to limitations mainly arising from federal law, the Fair Housing Act. One prominent issue that was reported widely in the news was the case of the founder of Community Recovery, which ran six sober living homes in Colorado. The founder was criminally charged in connection with sexual assault and insurance fraud.[9]

The Colorado Association of Recovery Residences (CARR) was formed in 2017.[10] One of the many purposes of CARR is to enforce national standards for recovery residences by using the adopted standards of the National Alliance of Recovery Residences. The website currently lists three businesses as CARR certified recovery residences: Mile High Sober Living, Red Rock Recovery, and Sobriety 1st Sober Living.[11] None of the CARR certified recovery residences are in Larimer County.

There are currently 55 Oxford House chapter residences in Colorado.[12] Oxford House is the umbrella organization for a network of more than 2,200 democratically-run, self-supporting, and drug-free group homes throughout the country.[13] Oxford House falls into the Level I category of the NARR standards. All Oxford House chapters are rented single-family homes, the average number of residents in a home is 8, and there are no co-ed homes. There are two Oxford House residences in Fort Collins and three in Loveland.

Federal Law

Federal laws such as the Fair Housing Act prohibit discrimination of protected classes, including on the basis of disability, which includes those in recovery. There have been cases in Colorado and other states where cities and counties adopted new, or employed existing, regulations to impose restrictions on recovery homes, only to be found in violation of the Fair Housing Act by the courts. Additionally, the Americans with Disabilities Act (ADA) requires that states, cities and homeowner associations provide "reasonable accommodations" to individuals with disabilities, including individuals in recovery.[14] Provisions of the ADA and the Fair Housing are intended to ensure that those in recovery can do so as a protected class as long as they are in the process.

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[8] Wittman, F. D., Polcin, D. L., & Sheridan, D. (2017). The Architecture of Recovery: Two Kinds of Housing Assistance for Chronic Homeless Persons with Substance Use Disorders. *Drugs and alcohol today*, *17*(3), 157-167.

[9] Osher, C.N. (March 11, 2018). Police found fraud, sex crimes in a Colorado sober-living home empire. The state doesn't regulate the industry. *The Denver Post.* Retrieved from https://www.denverpost.com/2018/03/11/colorado-sober-living-homes-opioid-crisis-christopher-bathum/

[10] Colorado Association of Recovery Residences (2018). *About Us.* Retrieved from https://coloradoassociationofrecoveryresidences.org/about/

[11] CARR (2018). *CARR Directory.* Accessed on March 4, 2019. Retrieved from https://carrdirectory.org/listings/?search_region=0&search_categories%5B%5D=498

[12] Oxford House (March 4, 2019). *Oxford Houses of Colorado-Directory.* Retrieved from http://oxfordhouse.org/pdf/co

[13] Oxford House (Jan. 2018). *Oxford House Annual Report Fiscal Year 2017.* Retrieved from https://www.oxfordhouse.org/userfiles/file/doc/ar2017.pdf

[14] U.S. Commission on Civil Rights (Oct 2000). *Sharing the Dream: Is the ADA Accommodating All?, Chapter 4*. Retrieved from https://www.usccr.gov/pubs/ada/ch4.htm

Colorado's Opioid-Related Litigation

Former Colorado Attorney General Cynthia Coffman filed a lawsuit against Purdue Pharma in September 2018 and alleged that their fraudulent and deceptive marketing of prescription opioids played a significant role in causing the opioid epidemic in Colorado.[15] After current Attorney General Phil Weiser was sworn-in in January 2019, he stated that he would continue the lawsuit commenced by Former Attorney General Coffman and possibly join other against additional drug companies on behalf of the state.[16] In a budget request amendment to the Joint Budget Committee, Attorney General Weiser requested $535,820 for fiscal year 2019-2020 and $565,607 for fiscal year 2020-2021 in order to "enhance the Department's efforts to manage current and future litigation needs to combat the opioid epidemic, improper prescriptions and deceptive sales practices of drug companies.[17]

This Legislation

A current program is administered by the Division of Housing, within the Department of Local Affairs (DOLA) which provides vouchers and other support services for housing assistance for people with a mental health disorder or co-occurring behavioral health disorder that is transitioning from the Department of Corrections, Division of Youth Services, or a county jail into the community. The bill adds to the program criteria people with a SUD and those that are in transition from a mental health institute to the community, an individual that is homeless or in an unstable housing environment and is transitioning from a residential treatment program, or is engaged in the community transition specialist program.[18] For fiscal year 2019-2020 and the subsequent four fiscal years, at least $4.3 million is to be continuously appropriated to the Division of Housing annually for the voucher program. Each year, DOLA will report to the Senate Committee on Health and Human Services, House Committee on Health and Insurance, and the House Committee on Public Health Care and Human Services, during the department's SMART Act[19] hearing. The report must include the number of projects funded, number of units in each funded project, number of qualified individuals housed as a result of the program, number of individuals who after receiving a voucher returned to the facility from where they were transitioning.

The bill defines "recovery residence" as, "any premises, place, or building that provides housing accommodation for individuals with a primary diagnosis of a SUD that is free from alcohol and non-prescribed or illicit drugs, promotes independent living and life skill development, and provides structured activities and recovery support services that are primarily intended to promote recovery from SUDs. A recovery residence does not include:

- A private residence in which an individual related to the owner of the residence by blood, adoption, or marriage is required to abstain from substance use or receive behavioral health services for a SUD as a condition of residing in the residence
- The supportive residential community for individuals that are homeless at Fort Lyon
- A facility approved for residential treatment by the Office of Behavioral Health (OBH)

After January 1, 2020, a person shall not operate a facility using the term "recovery residence", "sober living facility, "sober home, " or a similar term and a health provider or health facility shall not refer people to such a facility unless the facility is:

- Certified by the Colorado Association of Recovery Residences

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[15] CO Attorney General (Sept. 6, 2018). *Colorado Attorney General Cynthia Coffman Sues Purdue Pharma for its Role in Creating the Opioid Epidemic.* Retrieved from https://coag.gov/press-room/press-releases/09-06-18

[16] Sherry, A. (Jan. 9, 2019). What's Up First on Weiser's Agenda? ACA, Opioid Crisis and Bail Reform, for Starters. *Colorado Public Radio.* Retrieved from https://www.cpr.org/news/story/whats-up-first-on-weisers-agenda-aca-opioid-crisis-and-bail-reform-for-starters

[17] Colorado Attorney General (Jan. 15, 2019). *News Release: Attorney General Phil Weiser highlights priorities with budget request amendments to Joint Budget Committee.* Retrieved from https://coag.gov/sites/default/files/filefield_paths/ag_weiser_budget_priorities_release_final_1.15.19.pdf

[18] The community transition specialist program was established during the 2018 session with SB18-270, a bill that the Health District Board of Directors voted to support.

[19] State Measurement for Accountable, Responsive, and Transparent Government Act

- Is chartered by Oxford House
- Or has been operating as a recovery residence in the state for 30 or more years, as of the effective date of the bill

A person or a recovery residence owner, employee, administrator, or any of their relatives may not directly or indirectly solicit, accept, or receive a commission, payment, trade, fee, or anything that has monetary or material value:

- For the admission of a resident, except for state or federal contracts that specifically reimburse for resident fees
- From a treatment facility that is licensed or certified by the Department of Public Health and Environment (CDPHE) for the treatment of SUDs for resident fees
- From a facility approved for residential treatment by OBH

One of these individuals also cannot solicit, accept, or receive a commission, payment, trade, fee, or anything that has monetary or material value from a toxicology laboratory that provides confirmation testing or point-of-care testing for residents.

The bill establishes the "opioid crisis recovery funds advisory committee" in order to advise and collaborate with the Department of Law on the uses of any funds received by the state as a result of opioid-addiction-related litigation in which the funds are not predetermined or committed by court order. The Committee consists of appointed members, including:

- 13 members appointed by the Governor (physician, pharmacist, nurse, dentist, veterinarian, physical therapist, representative from a local public health agency, individual who has been affected by the opioid crisis, a family member of a person who has been affected by the opioid crisis, representative from an advocacy organization for people with SUDs, two individuals from a statewide group that represents counties- one from western slope and one from eastern part, representative from an association that represents behavioral health providers)
- 2 members appointed by Executive Director of Department of Human Services (one must represent an association of substance use providers)
- 2 members appointed by Executive Director of CDPHE (one must be a pain management patient)
- 1 member appointed by Executive Director of Department of Regulatory Agencies
- 1 member appointed by Executive Director of Department of Health Care Policy and Financing
- 1 member from the Substance Abuse Trend and Response Task Force, appointed by Attorney General
- 1 member from the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies, appointed by Director of the Center
- 1 member from each safety net hospital that provides addiction services, appointed by the hospital
- 1 member from the Colorado District Attorneys' Council appointed by the executive director
- 2 members from law enforcement agencies, 1 from the Colorado Association of Chiefs of Police and one from the County Sheriffs of Colorado
- 1 member from the Colorado Municipal League, appointed by the league's president

Appointments shall be made no later than 90 days after the state receives a settlement or damages award and the Attorney General is to notify the appointing authorities when the state receives such award. Each appointed member serves at the pleasure of the official the appointed them. Any vacancy on the committee is to be filled in the same method as the original appointment. If the state receives an award that is not predetermined or committed by court order, the Attorney General is to convene the committee for a meeting, and any subsequent meetings, to seek input and recommendations on the proper expenditure of the funds. Each member of the committee is to maintain confidentiality throughout the process. Members cannot disclose the contents of any request for funding with anyone outside the committee. Each member must affirm that they do not have a personal or financial interest regarding any organization that may

request funding. Members are to disclose all potential conflicts of interest to the Attorney General before reviewing funding requests.

This bill is effective upon the Governor's signature.

Fiscal Note

The bill requires the General Assembly to appropriate $4.3 million annually for five years, from FY 2019-20 to FY 2023-24. The majority of the fiscal note dated February 1, 2019, does not reflect the bill as amended in the House Public Health Care & Human Services Committee.

Reasons to Support

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

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

There is little oversight of the recovery residence industry, whereas other areas of the healthcare system are highly regulated by the state. Recovery residences, which house vulnerable patients, are currently essentially self-policed. Providing a method to account for the residences that market themselves as a recovery residence may aid in knowing how many are operating in the state, and assuring that they are meeting NARR's set of standards, may help with quality. For many individuals, receiving the portion of the continuum of SUD services appropriate to their needs, including the use of recovery residences when indicated, can lead to health and self-sufficiency.

The opioid crisis recovery funds advisory committee may be an important resource to the Attorney General if the state receives funds from opioid-related litigation that does not have court-mandated requirements. It is important that the Attorney General's office hear from a variety of stakeholders on the issue.

Supporters

- AspenPoint
- Boulder County
- Center for Health Progress
- City and County of Denver
- Colorado Academy of Family Physicians
- Colorado Association of Recovery Residences
- Colorado Behavioral Healthcare Council
- Colorado Chapter, College of Emergency Physicians
- Colorado Counties, Inc.
- Colorado Criminal Defense Bar
- Colorado Medical Society
- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- Colorado Psychiatric Society

- Colorado Public Health Association
- Colorado Society of Addiction Medicine
- Counties and Commissioners Acting Together (CCAT)
- David's House
- Denver Health and Hospital Authority
- Disability Law Colorado
- Housing Colorado
- Jefferson County Human Services
- Kaiser Permanente
- League of Women Voters of Colorado
- National Alliance on Mental Illness
- National Association of Social Workers, Colorado Chapter

Reasons to Oppose

One question is whether having the industry regulate itself offers strong enough protection for residents, or whether there needs to be objective oversight from those without a vested interest.

Some may voice concern that individuals with a SUD are given priority over other at-risk groups (older adults, those with disabilities) for housing vouchers. A SUD can be categorized as a disability, and some of those who fall into other at-risk groups also have a SUD. Others may assert that the funds for the voucher program should be directed to reducing waitlists for other existing housing programs that need the funds to decrease waitlists. Others may have a concern of allowing people to receive state-funded housing vouchers after relapse as they may believe that not revoking the voucher condones the person's substance use relapse.

Opponents

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

Other Considerations

In Larimer County, there is a desire to encourage the development of quality recovery residences that allow the continuation of medication-assisted treatment. There may be some point in the future where our community may want to use funding from the 1A ballot issue to help people either pay for, or receive services in, this type of facility. The language surrounding the receipt of fees or anything of value for the admission of individuals except in certain circumstances in not clear for this intent. If the facility that is to be built with 1A funds is licensed by OBH is licensed for residential treatment it may fall under this exception. Furthermore, there may be a bill introduced later in session to move licensing of facilities to the Department of Public Health and Environment, this bill does not address that possible change. If it passes the General Assembly before the introduction of such a bill, there may need to be clarification on the issue in the 2020 legislative session.

Social stigma and NIMBY (not in my back yard) attitudes toward substance use disorders, homelessness, and mental illness need to be addressed to assist in recovery and in finding residences that will accept the DOLA vouchers.

A recent study asserted that there is a need for further studies to address operational characteristics of recovery residences and their associations with outcomes.[20] The authors assert that important questions to consider include: What is the differential impact of housing that is affiliated with professional services, such as treatment or case management, versus housing that does not offer those services? What is the differential impact of houses that are primarily staff run versus peer run? What is the differential impact of houses that are communally organized (shared space) versus individually organized (private room or apartment)?

[20] Wittman, F. D., Polcin, D. L., & Sheridan, D. (2017). The Architecture of Recovery: Two Kinds of Housing Assistance for Chronic Homeless Persons with Substance Use Disorders. *Drugs and alcohol today*, *17*(3), 157-167.

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 summary 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

Memo

To: Board of Directors, Health District of Northern Larimer County

From: Alyson Williams, Policy Coordinator

Date: March 8, 2019

Re: Staff Recommendation on HB19-1009: Substance Use Disorder Recovery

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The Health District Public Policy Strategy Team recommends the Board of Directors support HB19-1009.

Health District
OF NORTHERN LARIMER COUNTY

Priority 1 Bills

3/8/2018

HB19-1001	**Hospital Transparency Measures To Analyze Efficacy**
Comment:	**Priority 1**
Position:	
Calendar Notification:	NOT ON CALENDAR
Short Title:	Hospital Transparency Measures To Analyze Efficacy
Sponsors:	C. Kennedy / D. Moreno
Summary:	The bill requires the department of health care policy and financing (department), in consultation with the Colorado healthcare affordability and sustainability enterprise board, to develop and prepare an annual report detailing uncompensated hospital costs and the different categories of expenditures made by hospitals in the state (hospital expenditure report). In compiling the hospital expenditure report, the department shall use publicly available data sources whenever possible. Each hospital in the state is required to make available to the department certain information. Prior to issuing the hospital expenditure report, each hospital referenced in the report shall have 15 days to review the report and submit clarifications or corrections to the department. Additionally, the department is required to provide a statewide hospital association any information it receives from hospitals in the development of the hospital expenditure report. The department is required to submit the hospital expenditure report to the governor, specified committees of the general assembly, and the medical services board in the department by January 15, 2020 and each year thereafter. The department is also directed to post the hospital expenditure report on the department's website. The bill requires the department, in consultation with the department of public health and environment and the division of insurance, to determine whether the hospital report card and the hospital charge report that exist under current law require any structural or substantive changes. Any such recommendations to that effect are required to be made to the general assembly by November 1, 2019. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*
Status:	1/4/2019 Introduced In House - Assigned to Health & Insurance 1/16/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole 1/28/2019 House Second Reading Laid Over Daily - No Amendments 1/29/2019 House Second Reading Passed with Amendments - Committee, Floor 1/30/2019 House Third Reading Laid Over Daily - No Amendments 1/31/2019 House Third Reading Passed - No Amendments 2/4/2019 Introduced In Senate - Assigned to Health & Human Services 3/7/2019 Senate Committee on Health & Human Services Refer Amended - Consent Calendar to Senate Committee of the Whole

Date Introduced: 2019-01-04

HB19-1004 Proposal For Affordable Health Coverage Option

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Proposal For Affordable Health Coverage Option

Sponsors: D. Roberts | M. Catlin / K. Donovan | J. Bridges

Summary: The bill requires the department of health care policy and financing and the division of insurance in the department of regulatory agencies (departments) to develop and submit a proposal (proposal) to certain committees of the general assembly concerning the design, costs, benefits, and implementation of a state option for health care coverage. Additionally, the departments shall present a summary of the proposal at the annual joint hearings with the legislative committees of reference during the interim before the 2020 legislative session.

The proposal must contain a detailed analysis of a state option and must identify the most effective implementation of a state option based on affordability to consumers at different income levels, administrative and financial burden to the state, ease of implementation, and likelihood of success in meeting the objectives described in the bill. The proposal must also identify any necessary changes to state law to implement the proposal.

In developing the proposal, the departments shall engage in a stakeholder process that includes public and private health insurance experts, consumers, consumer advocates, employers, providers, and carriers. Further, the departments shall review any information relating to a pilot program operated by the state personnel director as a result of legislation that may be enacted during the 2019 legislative session.

The departments shall prepare and submit any necessary federal waivers or state plan amendments to implement the proposal, unless a bill is filed within the filing deadlines for the 2020 legislative session that substantially alters the federal authorization required for the proposal and the bill is not postponed indefinitely in the first committee.

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

Status: 1/4/2019 Introduced In House - Assigned to Health & Insurance
1/23/2019 House Committee on Health & Insurance Refer Amended to Appropriations
2/28/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole
3/1/2019 House Second Reading Passed with Amendments - Committee, Floor
3/4/2019 House Third Reading Passed - No Amendments
3/7/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-04

HB19-1009 Substance Use Disorders Recovery

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Substance Use Disorders Recovery

Sponsors: C. Kennedy | J. Singer / K. Priola | B. Pettersen

Summary: **Opioid and Other Substance Use Disorders Study Committee.** The bill:

- ★ Expands the housing voucher program currently within the department of local affairs to include individuals with a substance use disorder and appropriates $4.3 million each of the next 5 fiscal years to support the program (**section 1**);
- ★ Requires each recovery residence operating in Colorado to be licensed by the department of public health and environment (**section 2**); and
- ★ Creates the opioid crisis recovery fund for money the state receives as settlement or damage awards resulting from opioid-related litigation (**section 3**).

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

Status: 1/4/2019 Introduced In House - Assigned to Public Health Care & Human Services + Appropriations
3/6/2019 House Committee on Public Health Care & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-04

HB19-1010 Freestanding Emergency Departments Licensure

Comment: **Priority 1**

Position: **Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Freestanding Emergency Departments Licensure

Sponsors: K. Mullica | L. Landgraf / B. Gardner | B. Pettersen

Summary: The bill creates a new license, referred to as a "freestanding emergency department license", for the department of public health and environment to issue on or after July 1, 2022, to a health facility that offers emergency care, that may offer primary and urgent care services, and that is either:

- ★ Owned or operated by, or affiliated with, a hospital or hospital system and located more than 250 yards from the main campus of the hospital; or
- ★ Independent from and not operated by or affiliated with a hospital or hospital system and not attached to or situated within 250 yards of, or contained within, a hospital.

A facility licensed as a community clinic before July 1, 2010, and that serves a rural community or ski area is excluded from the definition of "freestanding emergency department".

The bill allows the department to waive the licensure requirements for a facility that is licensed as a community clinic or that is seeking community clinic licensure and serves an underserved population in the state.

The state board of health is to adopt rules regarding the new license, including rules to set licensure requirements and fees and safety and care standards.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/4/2019 Introduced In House - Assigned to Health & Insurance
1/16/2019 House Committee on Health & Insurance Refer Amended to Finance
1/24/2019 House Committee on Finance Refer Unamended to Appropriations

2/12/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole
2/14/2019 House Second Reading Passed with Amendments - Committee
2/15/2019 House Third Reading Passed - No Amendments
2/19/2019 Introduced In Senate - Assigned to Health & Human Services
3/7/2019 Senate Committee on Health & Human Services Refer Unamended to Finance

Date Introduced: 2019-01-04

HB19-1019 Psychotherapists Continuing Competency Requirements

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Psychotherapists Continuing Competency Requirements

Sponsors: J. Coleman / A. Williams

Summary: The bill establishes continuing professional competency requirements for psychotherapists registered in Colorado by the state board of registered psychotherapists (board). The requirements mirror the continuing professional competency requirements established for social workers, marriage and family therapists, licensed professional counselors, and addiction counselors.

On or before March 1, 2020, the board is required to adopt rules establishing a continuing professional competency program that includes the following elements:

- A self-assessment of the knowledge and skills of a registered psychotherapist;
- The development, execution, and documentation of a learning plan; and
- Periodic demonstration of knowledge and skills through documentation of activities.

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

Status: 1/4/2019 Introduced In House - Assigned to Health & Insurance
1/29/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole
2/4/2019 House Second Reading Laid Over to 02/12/2019 - No Amendments
2/11/2019 House Second Reading Special Order - Laid Over to 02/14/2019 - No Amendments
2/14/2019 House Second Reading Passed with Amendments - Committee, Floor
2/15/2019 House Third Reading Lost - No Amendments

Date Introduced: 2019-01-04

HB19-1027 Clean Syringe Exchange Environmental Impact Report

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Clean Syringe Exchange Environmental Impact Report

Sponsors: S. Beckman

Summary: The bill requires an agency or nonprofit organization operating a clean syringe exchange program to submit an annual environmental impact mitigation plan (plan) to its county or district board of health detailing:

- The number of syringes received from clean syringe exchange program participants in the previous calendar year;
- The number of syringes given to clean syringe exchange program participants in the previous calendar year;
- The agency's or nonprofit organization's plan to minimize the number of syringes near the clean syringe exchange program location that have not been disposed of safely; and
- The agency's or nonprofit organization's plan to minimize the environmental impacts of unsafe or improper syringe disposal.

The county or district must forward the plan to the department of public health and environment (department). The department must compile the information received from all county and district boards of health and report the information to the general assembly during the department's "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing.

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

Status: 1/4/2019 Introduced In House - Assigned to Public Health Care & Human Services
1/23/2019 House Committee on Public Health Care & Human Services Postpone Indefinitely

Date Introduced: 2019-01-04

HB19-1033 Local Governments May Regulate Nicotine Products

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Local Governments May Regulate Nicotine Products

Sponsors: K. Tipper | C. Kennedy / R. Fields | K. Priola

Summary: **Sections 1, 2, and 4** of the bill authorize a county to enact a resolution or ordinance that prohibits a minor from possessing or purchasing cigarettes, tobacco products, or nicotine products. Sections 1 and 2 also authorize a county to impose regulations on cigarettes, tobacco products, or nicotine products that are more stringent than statewide regulations, including prohibiting sales to a person under 21 years of age, and section 4 expressly authorizes a county to enact a resolution or ordinance regulating the sale of cigarettes, tobacco products, or nicotine products to minors. Section 3 expressly authorizes a statutory or home rule city or town to enact an ordinance regulating the sale of cigarettes, tobacco products, or nicotine products to minors.

From state income tax money, the state currently apportions an amount equal to 27% of state cigarette tax revenues to cities, towns, and counties in proportion to the amount of state sales tax revenues collected within their boundaries. In order to receive their allocation of this money, cities, towns, and counties are prohibited from imposing their own fees, licenses, or taxes on cigarette sales or from attempting to impose a tax on cigarettes. **Section 5** removes this prohibition, thus allowing cities, towns, and counties to impose fees, licenses, or taxes on cigarette sales without losing their apportioned state cigarette tax revenues.

Section 6 authorizes a statutory or home rule city or town or a county, if approved by a vote of the people within the statutory or home rule city or town or county, to impose a special sales tax on the sale of cigarettes, tobacco products, or nicotine products and provides a mechanism by which a county's special sales tax applies to a municipality within the boundary of the county unless the municipality, if approved by a vote of the people within the municipality, enacts its own such special sales tax; however, the county and municipality may then enter into an intergovernmental agreement authorizing the county to continue to levy, collect, and enforce its special sales tax within the corporate limits of the municipality.

Section 7 makes a conforming amendment.
(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status:
1/4/2019 Introduced In House - Assigned to Health & Insurance
2/1/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole
2/5/2019 House Second Reading Passed with Amendments - Committee
2/6/2019 House Third Reading Passed - No Amendments
2/7/2019 Introduced In Senate - Assigned to Health & Human Services
2/14/2019 Senate Committee on Health & Human Services Refer Unamended to Senate Committee of the Whole
2/20/2019 Senate Second Reading Laid Over Daily - No Amendments
2/22/2019 Senate Second Reading Passed with Amendments - Floor
2/25/2019 Senate Third Reading Passed - No Amendments
3/1/2019 House Considered Senate Amendments - Result was to Laid Over Daily
3/1/2019 House Considered Senate Amendments - Result was to Laid Over to 03/01/2019
3/4/2019 House Considered Senate Amendments - Result was to Concur - Repass

Date Introduced: 2019-01-04

HB19-1038 Dental Services For Pregnant Women On Children's Basic Health Plan Plus

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification:
Wednesday, March 13 2019
SENATE HEALTH & HUMAN SERVICES COMMITTEE
Upon Adjournment LSB-B
(1) in senate calendar.

Short Title: Dental Services For Pregnant Women On Children's Basic Health Plan Plus

Sponsors: M. Duran | S. Lontine / J. Ginal | T. Story

Summary: Current law requires the medical services board to include dental services for eligible children enrolled in a children's basic health plan. The bill requires the board to include dental services to all eligible enrollees, which includes children and pregnant women.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status:
1/4/2019 Introduced In House - Assigned to Public Health Care & Human Services
1/23/2019 House Committee on Public Health Care & Human Services Refer Amended to Appropriations
2/22/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole
2/22/2019 House Second Reading Special Order - Passed with Amendments - Committee
2/25/2019 House Third Reading Passed - No Amendments
2/27/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-04

HB19-1044 Advance Behavioral Health Orders Treatment

Comment: **Priority 1- The Board voted to Support HB19-1044 but urged lawmakers to consider amendments that would create a clause on the form that would give an individual the ability to choose whether or not their agent would have the authority to override the document, similar to the options currently available in health advance care directives.**

Position: **Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Advance Behavioral Health Orders Treatment

Sponsors: T. Kraft-Tharp | L. Landgraf / N. Todd | D. Coram

Summary: Under current law, an adult may establish advance medical orders for scope of treatment, allowing an adult to establish directives for the administration of medical treatment in the event the adult later lacks decisional capacity to provide informed consent to, withdraw from, or refuse medical treatment.

The bill creates a similar order for behavioral health orders for scope of treatment so that an adult may communicate his or her behavioral health history, decisions, and preferences.

The bill:

- ★ Lists the requirements for a behavioral health orders for scope of treatment form;
- ★ Details the duties and immunities of emergency medical services personnel, health care providers, and health care facilities with respect to treating an adult with behavioral health orders for scope of treatment;
- ★ Details how a behavioral health orders for scope of treatment form is executed, amended, or revoked; and
- ★ Prohibits an effect on a health insurance contract, life insurance contract, or annuity, by executing or failing to execute a behavioral health orders for scope of treatment.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/4/2019 Introduced In House - Assigned to Public Health Care & Human Services
1/23/2019 House Committee on Public Health Care & Human Services Refer Amended to House Committee of the Whole
1/25/2019 House Second Reading Passed with Amendments - Committee, Floor
1/28/2019 House Third Reading Passed - No Amendments
1/29/2019 Introduced In Senate - Assigned to Health & Human Services
2/21/2019 Senate Committee on Health & Human Services Refer Amended to Senate Committee of the Whole
2/26/2019 Senate Second Reading Passed with Amendments - Committee
2/27/2019 Senate Third Reading Passed with Amendments - Floor
2/28/2019 House Considered Senate Amendments - Result was to Laid Over to 03/01/2019
3/1/2019 House Considered Senate Amendments - Result was to Laid Over Daily
3/4/2019 House Considered Senate Amendments - Result was to Concur - Repass

Date Introduced: 2019-01-04

HB19-1076 Clean Indoor Air Act Add E-cigarettes Remove Exceptions

Comment: **Priority 1**

Position: **Support**

Calendar Notification: Friday, March 15 2019
GENERAL ORDERS - SECOND READING OF BILLS
(1) in house calendar.

Short Title: Clean Indoor Air Act Add E-cigarettes Remove Exceptions

Sponsors: D. Michaelson Jenet | C. Larson / K. Priola | K. Donovan

Summary: The bill amends the "Colorado Clean Indoor Air Act" by:

- Adding a definition of "electronic smoking device" (ESD) to include e-cigarettes and similar devices within the scope of the act;
- Citing the results of recent research on ESD emissions and their effects on human health as part of the legislative declaration;
- Eliminating the existing exceptions for certain places of business in which smoking may be permitted, such as airport smoking concessions, businesses with 3 or fewer employees, designated smoking rooms in hotels, and designated smoking areas in assisted living facilities; and
- Repealing the ability of property owners and managers to designate smoking and nonsmoking areas through the posting of signs.

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

Status: 1/11/2019 Introduced In House - Assigned to Health & Insurance
2/27/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole

Date Introduced: 2019-01-14

HB19-1077 Pharmacist Dispense Drug Without Prescription In Emergency

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Pharmacist Dispense Drug Without Prescription In Emergency

Sponsors: D. Roberts / J. Tate | B. Pettersen

Summary: The bill allows a pharmacist to dispense an emergency supply of a chronic maintenance drug to a patient without a prescription if:

- The pharmacist is unable to obtain authorization to refill the prescription from a health care provider;
- The pharmacist has a record of a prescription in the name of the patient who is requesting the emergency supply of the chronic maintenance drug or, in the pharmacist's professional judgment, the refusal to dispense an emergency supply will endanger the health of the patient;
- The amount of the chronic maintenance drug dispensed does not exceed the amount of the most recent prescription or the standard quantity or unit of use package dispensed of the drug;
- The pharmacist has not dispensed an emergency supply of the chronic maintenance drug to the same patient in the previous 12-month period; and
- The prescriber of the drug has not indicated that no emergency refills are authorized.

The bill requires the state board of pharmacy to promulgate rules to establish standard procedures for dispensing chronic maintenance drugs. A pharmacist, the pharmacist's employer, and the original prescriber of the drug are not civilly liable for dispensing a chronic maintenance drug unless there is negligence, recklessness, or willful or wanton misconduct.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/11/2019 Introduced In House - Assigned to Health & Insurance
1/23/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole
1/25/2019 House Second Reading Passed with Amendments - Committee, Floor
1/28/2019 House Third Reading Passed - No Amendments

1/29/2019 Introduced In Senate - Assigned to Health & Human Services
2/20/2019 Senate Committee on Health & Human Services Refer Amended - Consent Calendar to Senate Committee of the Whole
2/25/2019 Senate Second Reading Passed with Amendments - Committee
2/26/2019 Senate Third Reading Passed - No Amendments
2/28/2019 House Considered Senate Amendments - Result was to Laid Over to 03/01/2019
3/4/2019 House Considered Senate Amendments - Result was to Concur - Repass
3/6/2019 House Considered Senate Amendments - Result was to Laid Over Daily
3/6/2019 House Considered Senate Amendments - Result was to Laid Over Daily
3/6/2019 House Considered Senate Amendments - Result was to Laid Over Daily

Date Introduced: 2019-01-11

HB19-1108 **Nonresident Electors And Special Districts**

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Nonresident Electors And Special Districts

Sponsors: L. Liston | E. Hooton / J. Tate

Summary: **Section 1** of the bill expands the definition of "eligible elector", as used in reference of persons voting in special district elections, to include a natural person who owns, or whose spouse or civil union partner owns, taxable real or personal property situated within the boundaries of the special district or the area to be included in the special district and who has satisfied all other requirements in the bill for registering to vote in an election of a special district but who is not a resident of the state.

Section 2 prohibits a person from voting in a special district election unless that person is an eligible elector as defined by the bill. The section also requires any natural person desiring to vote at any election as an eligible elector to sign a self-affirmation that the person is an elector of the special district. The bill specifies the form the affirmation must take.

Section 3 specifies procedures by which the eligible elector who is an eligible elector in another state becomes registered to be able to vote in the special district election. This section also contains an affirmation to be executed by the voter upon completing his or her application for registration. The oath or affirmation must be notarized by the elector.

Section 3 also permits any special district organized under the laws of the state, upon passage of a resolution by the board of the district (board), to allow an elector whose eligibility has been established through the procedures specified in the bill to vote for candidates for the board of directors of the special district. The bill makes clear that no person who is designated as an eligible elector is permitted to cast a ballot at any special district election without first having been registered within the time and in the manner required by the bill.

The bill only applies to a special district whose:

- ★ Board, by resolution, permits an eligible elector who is not a resident of the state to vote in elections of the special district; and
- ★ Regular special district election is not conducted as part of a general, primary, or coordinated election.

A county clerk and recorder is not required to either contract with a special district that permits the registration of noneligible resident electors in connection with the provision of any services or to administer any regular special district election conducted by the special district.

A person who is designated as an eligible elector in accordance with the bill is only permitted to vote in an election of the special district with which the person has registered and for a candidate for the board of directors of the special district who is listed on the ballot of the special district with

which the elector is registered. A person who is designated as an eligible elector in accordance with the bill is only permitted to vote for candidates for the board and is not authorized to vote for any other candidates or ballot issues or ballot questions that may appear on the regular ballot of the special district.

The bill describes procedures by which an eligible elector who is a resident of another state registers to vote with the special district.

The form used to register an eligible elector under the bill must contain a question asking the elector to confirm that he or she desires to receive a ballot from the special district. Unless the elector has executed the form to indicate that he or she desires to receive a ballot from the special district, the designated election official is not required to send a ballot to the elector. The special district is solely responsible for maintaining the list of nonresident owners of property within the special district who are eligible to vote in an election of the special district.

Section 4 contains procedures for verifying the signature of a ballot returned by a nonresident eligible elector with the signature of the elector on the notarized registration form required by the bill.

Section 5 authorizes each special district board to select, in an exercise of its own discretion and by majority vote of the board's voting members, one or more additional board members, each of whom shall serve as a nonvoting member of the board. A member of the board appointed for this purpose must be a person who is a nonresident of the state but is otherwise eligible to cast a ballot in elections of the special district in accordance with the bill. A board with 3 members may appoint no more than one nonvoting member of the board. A board with 5 members may appoint no more than 2 nonvoting members of the board. The term of such board members is 4 years subject to renewal of one or more additional 4-year terms in the discretion of a majority of the voting members of the board. Any board member appointed for this purpose may be removed for cause at any time by a majority of the voting members of the board.
(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/14/2019 Introduced In House - Assigned to State, Veterans, & Military Affairs
1/31/2019 House Committee on State, Veterans, & Military Affairs Refer Amended to House Committee of the Whole
2/5/2019 House Second Reading Laid Over Daily - No Amendments
2/8/2019 House Second Reading Laid Over to 02/11/2019 - No Amendments
2/11/2019 House Second Reading Laid Over to 02/14/2019 - No Amendments
2/15/2019 House Second Reading Passed with Amendments - Committee, Floor
2/19/2019 House Third Reading Passed - No Amendments
2/20/2019 Introduced In Senate - Assigned to State, Veterans, & Military Affairs
3/6/2019 Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely

Date Introduced: 2019-01-14

HB19-1120 Youth Mental Health Education And Suicide Prevention

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Youth Mental Health Education And Suicide Prevention

Sponsors: D. Michaelson Jenet | D. Roberts / S. Fenberg | D. Coram

Summary: The bill allows a minor 12 years of age or older to seek and obtain psychotherapy services with or without the consent of the minor's parent or guardian. A registered psychotherapist or licensed social worker providing psychotherapy services to a minor may, with the consent of the minor, advise the minor's parent or legal guardian of the psychotherapy services provided.

The bill requires the department of education, in consultation with the office of suicide prevention (office), the youth advisory council, and the suicide prevention commission, to create and maintain a mental health education literacy resource bank. The resource bank is available to the public free of charge.

The bill requires the state board of education to adopt standards related to mental health, including suicide prevention.

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

Status: 1/16/2019 Introduced In House - Assigned to Public Health Care & Human Services + Appropriations
2/20/2019 House Committee on Public Health Care & Human Services Witness Testimony and/or Committee Discussion Only
3/1/2019 House Committee on Public Health Care & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-16

HB19-1131 Prescription Drug Cost Education

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Prescription Drug Cost Education

Sponsors: S. Jaquez Lewis / F. Winter

Summary: The bill requires a drug manufacturer or wholesaler, or an agent or an employee of the manufacturer or wholesaler, to provide, in writing, the wholesale acquisition cost of a prescription drug to an entity or individual with whom the manufacturer, wholesaler, agent, or employee is sharing information concerning the drug.

The bill also requires the drug manufacturer or wholesaler, or an agent or employee of the manufacturer or wholesaler, to provide educational materials about the acquisition costs of other prescription drugs in the same therapeutic class.

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

Status: 1/25/2019 Introduced In House - Assigned to Health & Insurance
2/20/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole
2/25/2019 House Second Reading Laid Over Daily - No Amendments
2/25/2019 House Second Reading Laid Over to 02/27/2019 - No Amendments
2/26/2019 House Second Reading Laid Over to 02/28/2019 - No Amendments
3/1/2019 House Second Reading Passed with Amendments - Committee, Floor
3/4/2019 House Third Reading Passed - No Amendments
3/7/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-25

HB19-1154 Patient Choice Of Pharmacy

Comment: **Priority 1**

Position:

Calendar NOT ON CALENDAR

Notification:

Short Title: Patient Choice Of Pharmacy

Sponsors: M. Catlin | K. Mullica / J. Danielson | D. Coram

Summary: The bill prohibits a carrier that offers or issues a health benefit plan that covers pharmaceutical services, including prescription drug coverage, or a pharmacy benefit management firm managing those benefits for a carrier, from:

- Limiting or restricting a covered person's ability to select a pharmacy or pharmacist if certain conditions are met;
- Imposing a copayment, fee, or other cost-sharing requirement for selecting a pharmacy of the covered person's choosing;
- Imposing other conditions on a covered person, pharmacist, or pharmacy that limit or restrict a covered person's ability to use a pharmacy of the covered person's choosing; or
- Denying a pharmacy or pharmacist the right to participate in any of its pharmacy network contracts in this state or as a contracting provider in this state if the pharmacy or pharmacist has a valid license in Colorado and the pharmacy or pharmacist agrees to specified conditions

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

Status: 1/29/2019 Introduced In House - Assigned to Health & Insurance
2/13/2019 House Committee on Health & Insurance Postpone Indefinitely

Date Introduced: 2019-01-29

HB19-1160 Mental Health Facility Pilot Program

Comment: **Priority 1- The Board voted to support the concept of the bill but urged legislators to consider amendments to strengthen the bill, such as providing incentives for entities to participate, altering the application requirements, and clarifying language regarding the types of entities eligible to apply.**

Position: **Neutral**

Calendar Notification: NOT ON CALENDAR

Short Title: Mental Health Facility Pilot Program

Sponsors: L. Landgraf | J. Singer / B. Gardner

Summary: The bill creates a new 3-year mental health facility pilot program to provide residential care, treatment, and services to persons with both a mental health diagnosis and a physical health diagnosis. It contains requirements for applicants and directs the department of public health and environment to select one or 2 applicants for the pilot program.

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

Status: 1/30/2019 Introduced In House - Assigned to Public Health Care & Human Services + Appropriations
2/27/2019 House Committee on Public Health Care & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-30

HB19-1168 State Innovation Waiver Reinsurance Program

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: State Innovation Waiver Reinsurance Program

Sponsors: J. McCluskie | J. Rich / K. Donovan | B. Rankin

Summary: The bill authorizes the commissioner of insurance to apply to the secretary of the United States department of health and human services for a state innovation waiver, for federal funding, or both, to allow the state to implement and operate a reinsurance program to assist health insurers in paying high-cost insurance claims. The state cannot implement the program absent waiver or funding approval from the secretary. The program is established as an enterprise for purposes of section 20 of article X of the state constitution. The division of insurance is to include an update regarding the program in its annual "SMART Act" report, and the program is subject to sunset review and repeal in 5 years.

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

Status: 2/1/2019 Introduced In House - Assigned to Health & Insurance
2/27/2019 House Committee on Health & Insurance Refer Amended to Appropriations

Date Introduced: 2019-02-01

HB19-1169 Mental Health Involuntary Transportation Holds

Comment: **Priority 1- The Board voted to Strongly Support HB19-1169 but urged lawmakers to consider an amendment to add language about requiring the receiving facility to conduct an evaluation within a reasonable amount of time.**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Mental Health Involuntary Transportation Holds

Sponsors: J. Arndt / J. Cooke

Summary: Current law allows specified intervening professionals to transport to a treatment facility any person who appears to be in need of an immediate evaluation for treatment of a mental health disorder to prevent physical or psychiatric harm to others or to himself or herself. The authority to involuntarily hold such a person in custody expires upon the delivery of the person to the facility. The bill adds language to clarify that the authority to hold the person remains in effect until the evaluation is completed and a determination is made concerning the need for continued emergency evaluation and treatment.
(Note: This summary applies to this bill as introduced.)

Status: 2/4/2019 Introduced In House - Assigned to Public Health Care & Human Services
3/1/2019 House Committee on Public Health Care & Human Services Postpone Indefinitely

Date Introduced: 2019-02-04

HB19-1174 Out-of-network Health Care Services

Comment: **Priority 1**

Position: **Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Out-of-network Health Care Services

Sponsors: D. Esgar | M. Catlin / B. Gardner | B. Pettersen

Summary: The bill:

- ★ Requires health insurance carriers, health care providers, and health care facilities to provide patients covered by health benefit plans with information concerning the provision of services by out-of-network providers and in-network and out-of-network facilities;
- ★ Outlines the disclosure requirements and the claims and payment process for the provision of out-of-network services;
- ★ Requires the commissioner of insurance, the state board of health, and the director of the division of professions and occupations in the department of regulatory agencies to promulgate rules that specify the requirements for disclosures to consumers, including the timing, the format, and the contents and language in the disclosures;
- ★ Establishes the reimbursement amount for out-of-network providers that provide health care services to covered persons at an in-network facility and for out-of-network providers or facilities that provide emergency services to covered persons; and
- ★ Creates a penalty for failure to comply with the payment requirements for out-of-network health care services.

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

Status: 2/7/2019 Introduced In House - Assigned to Health & Insurance
3/6/2019 House Committee on Health & Insurance Refer Amended to Appropriations

Date Introduced: 2019-02-07

HB19-1176 Health Care Cost Savings Act of 2019

Comment: **Priority 1**

Position:

Calendar Notification: Tuesday, March 12 2019
Health & Insurance
Upon Adjournment Room 0107
(1) in house calendar.

Short Title: Health Care Cost Savings Act of 2019

Sponsors: E. Sirota | S. Jaquez Lewis / M. Foote

Summary: The bill creates the health care cost analysis task force (task force). The president of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives shall each appoint 2 legislative members to the task force. The governor shall appoint 9 members to the task force. The executive directors of the departments of human services, public health and environment, and health care policy and financing, or their designees, also serve on the task force.

The task force is required to issue a request for proposals and select an analyst to complete a health care cost analysis of 4 health care financing systems. The health care financing systems to be analyzed are:

- ★ The current health care financing system, in which residents receive health care coverage from private and public insurance carriers or are uninsured;
- ★ A public option system in which health benefit plans are sold through, and revenues and premiums are received from, the Colorado health benefit exchange, with additional funding as necessary through the general fund;

- A multi-payer universal health care financing system, in which competing insurance carriers or health maintenance organizations receive payments from a public financing authority; and
- A publicly financed and privately delivered universal health care system that directly compensates providers.

The analyst is required to use the same specified criteria when conducting the analysis of each health care financing system.

The task force is required to report the findings of the analyst to the general assembly.

The task force may seek, accept, and expend gifts, grants, and donations for the analysis. The general assembly may appropriate money to the health care cost analysis cash fund for the purposes of the task force, the analysis, and reporting requirements.

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

Status: 2/12/2019 Introduced In House - Assigned to Health & Insurance

Date Introduced: 2019-02-12

HB19-1193 **Behavioral Health Supports For High-risk Families**

Comment: **Priority 1**

Position:

Calendar Notification: Friday, March 8 2019
Public Health Care & Human Services
Upon Adjournment Room 0107
(2) in house calendar.

Short Title: Behavioral Health Supports For High-risk Families

Sponsors: L. Herod | R. Pelton / L. Garcia

Summary: The bill amends existing programs that provide access to substance use disorder treatment to pregnant and parenting women. The bill creates child care pilot programs for parenting women engaged in substance use disorder treatment. The bill:

- Defines "parenting women" as women up to one year postpartum who are in need of substance use disorder services;
- Encourages health care practitioners and county human or social services departments to identify pregnant women and parenting women for a needs assessment to determine needed services;
- Authorizes the department to use state money to provide residential substance use disorder treatment to pregnant and parenting women until such time as those services are covered under the state program of medical assistance, and authorizes the department of health care policy and financing to seek federal changes to permit treatment for this population, if necessary;
- Creates the high-risk families cash fund (cash fund) for the office of behavioral health in the department of human services to provide services to high-risk parents, including pregnant and parenting women, and for services for high-risk children and youth with behavioral health disorders. Further, money in the cash fund may be used to increase treatment capacity.
- Requires the state treasurer to transfer to the cash fund any unencumbered and unexpended money appropriated annually to certain programs listed in the bill, and requires annual reporting on the use of money from the cash fund;
- Creates the child care services and substance use disorder treatment pilot program (pilot program) as a two-generation initiative in the department of human services;
- Awards pilot program grants to enhance existing child care resource and referral programs and increase child care navigation capacity in one urban and one rural site to serve pregnant and parenting women seeking or participating in substance use disorder treatment;

- ★ Awards pilot program grants to enhance the capacity of the existing child care resource and referral program's centralized call center to serve pregnant and parenting women with a substance use disorder;
- ★ Awards pilot program grants to pilot a regional mobile child care model to serve young children of parenting women in substance use disorder treatment;
- ★ Requires an annual appropriation of $500,000 for 3 fiscal years for the pilot program, and requires annual reporting to the general assembly concerning the pilot program. Any money not expended for the pilot program will be transferred to the high-risk families cash fund.
- ★ Prohibits the admission into evidence in criminal proceedings information relating to substance use during pregnancy, with certain exceptions, that is obtained as part of providing postpartum care for up to one year postpartum or disclosed while women are seeking or participating in behavioral health treatment.

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

Status: 2/20/2019 Introduced In House - Assigned to Public Health Care & Human Services + Appropriations

Date Introduced: 2019-02-21

HB19-1211 **Prior Authorization Requirements Health Care Service**

Comment: **Priority 1**

Position:

Calendar Notification: Wednesday, March 13 2019
Health & Insurance
1:30 p.m. Room 0107
(2) in house calendar.

Short Title: Prior Authorization Requirements Health Care Service

Sponsors: D. Michaelson Jenet | Y. Caraveo / A. Williams

Summary: With regard to the prior authorization process used by carriers or private utilization review organizations (organizations) acting on behalf of carriers to review and determine whether a particular health care service prescribed by a health care provider is approved as a covered benefit under the patient's health benefit plan, the bill requires carriers and organizations to:

- ★ Publish and update their prior authorization requirements and restrictions;
- ★ Comply with deadlines established in the bill for making a determination on a prior authorization request;
- ★ Use current, clinically based prior authorization criteria that are aligned with other quality initiatives of the carrier or organization and with other carriers' and organizations' prior authorization criteria for the same health care service;
- ★ Limit the use of prior authorization to providers whose prescribing or ordering patterns differ significantly from the patterns of their peers after adjusting for patient mix and other relevant factors; and
- ★ Exempt from prior authorization providers with an 80% approval rate of prior authorization requests over the previous 12 months, and conduct annual reevaluation of a provider's eligibility for the exemption.

If a carrier or organization fails to make a determination within the time required or fails to apply prior authorization requirements or exempt providers from prior authorization requirements, the request is deemed approved.

An approved prior authorization request is valid for at least 180 days and continues for the duration of the prescribed or ordered course of treatment and the covered person's plan year.

The commissioner of insurance is authorized to adopt rules as necessary to implement the bill.

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

Status: 2/25/2019 Introduced In House - Assigned to Health & Insurance

Date Introduced: 2019-02-25

HB19-1216 Reduce Insulin Prices

Comment: **Priority 1**

Position:

Calendar Notification: Wednesday, March 20 2019
Health & Insurance
1:30 p.m. Room 0107
(1) in house calendar.

Short Title: Reduce Insulin Prices

Sponsors: D. Roberts / K. Donovan | K. Priola

Summary: The bill requires a carrier to reduce the cost sharing a covered person is required to pay for prescription insulin drugs by an amount equal to the greater of 51% of the total rebates received by the carrier per prescription insulin drug including price protection rebates or an amount that ensures cost sharing will not exceed 125% of the carrier's cost for the prescription insulin drug, subject to a maximum out-of-pocket cost of $100 per one-month supply of insulin.

The bill requires the department of law to investigate the pricing of prescription insulin drugs and submit a report of its findings to the governor, the commissioner of insurance, and the judiciary committees of the senate and house of representatives.

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

Status: 2/28/2019 Introduced In House - Assigned to Health & Insurance

Date Introduced: 2019-02-28

SB19-004 Address High-cost Health Insurance Pilot Program

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Address High-cost Health Insurance Pilot Program

Sponsors: K. Donovan / D. Roberts

Summary: **Sections 1 and 2** of the bill authorize the state personnel director to explore the feasibility of offering and, if feasible, to develop and implement a one-year pilot program in a limited geographic region of the state affected by high health insurance premiums to provide access to individuals in that region to participate in the group medical benefit plans offered to state employees. The pilot program would be available:

- In the portions of Eagle and Garfield counties that are within the service area of the state group benefit plans;
- To a limited number of individuals whose household income is more than 400 % but not more than 500 % of the federal poverty line; and

★ In the 2019-20 benefit plan year.

Section 2 outlines the factors for the state personnel director to consider in determining the feasibility of the pilot program.

Sections 3 through 15 modernize laws authorizing health care cooperatives in the state to incorporate consumer protections such as coverage for preexisting conditions and to encourage consumers to help control health care costs by negotiating rates on a collective basis directly with providers. *(Note: This summary applies to this bill as introduced.)*

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-04

SB19-005 Import Prescription Drugs From Canada

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Import Prescription Drugs From Canada

Sponsors: R. Rodriguez | J. Ginal / S. Jaquez Lewis

Summary: The bill creates the "Colorado Wholesale Importation of Prescription Drugs Act", under which the department of health care policy and financing (department) shall design a program to import prescription pharmaceutical products from Canada for sale to Colorado consumers. The program design must ensure both drug safety and cost savings for Colorado consumers. The department shall submit the program design to the secretary of the United States department of health and human services and request the secretary's approval of the program, as required by federal law, to import Canadian pharmaceutical products.

If the secretary approves the program, the department shall implement the program. The department shall adopt a funding mechanism to cover the program's administrative costs, and the department shall annually report on the program to the general assembly.

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

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
1/31/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-04

SB19-008 Substance Use Disorder Treatment In Criminal Justice System

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Substance Use Disorder Treatment In Criminal Justice System

Sponsors: K. Priola | B. Pettersen / C. Kennedy | J. Singer

Summary: **Opioid and Other Substance Use Disorders Study Committee. Section 1** of the bill requires the Colorado commission on criminal and juvenile justice to study and make recommendations concerning:

- Alternatives to filing criminal charges against individuals with substance use disorders who have been arrested for drug-related offenses;
- Best practices for investigating unlawful opioid distribution in Colorado; and
- A process for automatically sealing criminal records for drug offense convictions.

Section 2 of the bill requires the department of corrections (DOC) to allow medication-assisted treatment to be provided to persons who were receiving treatment in a local jail prior to being transferred to the custody of the DOC. The DOC may enter into agreements with community agencies and organizations to assist in the development and administration of medication-assisted treatment.

Section 3 of the bill contains a legislative declaration that the substance abuse trend and response task force should formulate a response to current and emerging substance abuse problems from the criminal justice, prevention, and treatment sectors that includes the use of drop-off treatment services, mobile and walk-in crisis centers, and withdrawal management programs as an alternative to entry into the criminal justice system for offenders of low-level drug offenses.

Section 4 of the bill directs the department of health care policy and financing to seek federal authorization under the Medicaid program for treatment of substance use disorders for persons confined in jails.

Section 5 of the bill creates a simplified process for sealing convictions for level 4 drug felonies, all drug misdemeanors, and any offense committed prior to October 1, 2013, that would have been a level 4 drug felony or drug misdemeanor if committed on or after October 1, 2013. A defendant may file a motion to seal records 3 years or more after final disposition of the criminal proceedings. Conviction records may be sealed only after a hearing and upon court order.

Section 6 of the bill requires jails that receive funding through the jail-based behavioral health services program to allow medication-assisted treatment to be provided to individuals in the jail. The jail may enter into agreements with community agencies and organizations to assist in the development and administration of medication-assisted treatment.

Section 7 of the bill provides an appropriation, including for the following programs funded through the annual long appropriations act:

- Increasing from 4 to 10 the number of the law-enforcement-assisted diversion pilot programs; and
- Increasing coresponder funding for criminal justice diversion pilot programs in the office of behavioral health in the department of human services.

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

Status: 1/4/2019 Introduced In Senate - Assigned to Judiciary

Date Introduced: 2019-01-04

SB19-010 Professional Behavioral Health Services For Schools

Comment: **Priority 1**

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Professional Behavioral Health Services For Schools

Sponsors: R. Fields / B. McLachlan | D. Valdez

Summary: The bill allows grant money to be used for behavioral health care services at recipient schools and specifies that grants may also fund behavioral health services contracts with community providers. The bill requires the department of education (department) to prioritize grant applications based on the

school's need for additional health professionals, and grant applicants must specify the extent to which the school has seen an increase in activities or experiences that affect students' mental well-being.

The bill allows a community provider to commit money to schools. It also changes the amount the department can expend to offset the costs incurred in implementing the program from 3% to 5% of money appropriated for the program.

The bill allows school districts to enter into agreements with specified groups to implement evidence-based, school-wide behavior supports and strategies to build and support positive school climates, including providing behavioral health services and supports; implement strategies to reduce the incidence of suspension and expulsion; and implement alternatives to suspension or expulsion.

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

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
1/17/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-04

SB19-012 Use Of Mobile Electronic Devices While Driving

Comment: **Priority 1**

Position: **Support**

Calendar Notification: Friday, March 8 2019
SENATE APPROPRIATIONS COMMITTEE
7:30 AM LSB-B
(2) in senate calendar.

Short Title: Use Of Mobile Electronic Devices While Driving

Sponsors: L. Court / J. Melton

Summary: Current law prohibits the use of wireless telephones while driving for individuals who are younger than 18 years of age. The bill:

- ★ Extends the prohibition to drivers of all ages;
- ★ Extends the existing prohibition of the use of wireless telephones to include all mobile electronic devices;
- ★ Establishes the penalties as $300 and 4 points for a first violation, $500 and 6 points for a second violation, and $750 and 8 points for a third or subsequent violation;
- ★ Creates an exception to the prohibition of the use of mobile electronic devices for drivers who use a mobile electronic device while a hands-free accessory is engaged; and
- ★ Repeals a sentence enhancement for a violation that causes bodily injury or death.

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

Status: 1/4/2019 Introduced In Senate - Assigned to Transportation & Energy
2/14/2019 Senate Committee on Transportation & Energy Refer Amended to Appropriations
3/8/2019 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Date Introduced: 2019-01-04

SB19-015 Create Statewide Health Care Review Committee

Comment: **Priority 1**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Create Statewide Health Care Review Committee

Sponsors: J. Ginal / S. Beckman

Summary: The bill recreates the former health care task force, renamed as the statewide health care review committee, to study health care issues that affect Colorado residents throughout the state. The committee consists of the members of the house of representatives committees on health and insurance and public health care and human services and the senate committee on health and human services. The committee is permitted to meet up to 2 times during the interim between legislative sessions, including 2 field trips.
(Note: This summary applies to this bill as introduced.)

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
1/17/2019 Senate Committee on Health & Human Services Refer Unamended to Appropriations

Date Introduced: 2019-01-04

SB19-041 Health Insurance Contract Carrier And Policyholder

Comment: **Priority 1**

Position:

Calendar Notification: Wednesday, March 13 2019
Health & Insurance
1:30 p.m. Room 0107
(1) in house calendar.

Short Title: Health Insurance Contract Carrier And Policyholder

Sponsors: J. Smallwood | F. Winter / T. Kraft-Tharp

Summary: Current law requires a contract between a health insurance carrier and a policyholder to contain a provision that requires the policyholder to pay premiums for each individual covered under the policy through the date that the policyholder notifies the carrier that an individual covered under the policy is no longer covered. The bill allows the contract to state that, in the alternative, the policyholder is required to pay premiums to the carrier through the date that the individual covered under the policy is no longer eligible or covered if the policyholder notifies the carrier within 10 business days after the date of ineligibility or noncoverage because the individual left employment without notice to the employer or the employee was terminated for gross misconduct.

The bill also clarifies that:

- If the policyholder notifies the carrier within the 10-day period, the carrier is not required to provide benefits to the individual after the date that the individual is no longer eligible or covered; and
- A carrier and a policyholder may agree to a different date where premium payments are not required.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
2/14/2019 Senate Committee on Health & Human Services Refer Amended to Senate Committee of the Whole

	2/20/2019 Senate Second Reading Passed with Amendments - Committee 2/21/2019 Senate Third Reading Passed - No Amendments 2/22/2019 Introduced In House - Assigned to Health & Insurance
Date Introduced:	2019-01-04

SB19-062 Limit Agency Rule-making Authority To Amend Rules

Comment:	**Priority 1**
Position:	
Calendar Notification:	NOT ON CALENDAR
Short Title:	Limit Agency Rule-making Authority To Amend Rules
Sponsors:	J. Sonnenberg
Summary:	The bill requires an executive agency with rule-making authority to obtain additional statutory rule-making authority to amend or reinterpret an existing rule unless the rule is amended or reinterpreted based on: ★ The rule's expiration or pending expiration as a result of its inclusion in the annual rule review bill; or ★ A determination that the existing rule has been rendered unconstitutional or otherwise in contravention of the law based on a court decision or changes made to state or federal statutes, federal regulations, or the state or federal constitution. Any rule that an agency promulgates or reinterprets without complying with the requirement to obtain additional statutory rule-making authority is void. *(Note: This summary applies to this bill as introduced.)*
Status:	1/10/2019 Introduced In Senate - Assigned to State, Veterans, & Military Affairs 1/28/2019 Senate Committee on State, Veterans, & Military Affairs Postpone Indefinitely
Date Introduced:	2019-01-10

SB19-079 Electronic Prescribing Controlled Substances

Comment:	**Priority 1**
Position:	
Calendar Notification:	Friday, March 8 2019 GENERAL ORDERS - SECOND READING OF BILLS (8) in house calendar.
Short Title:	Electronic Prescribing Controlled Substances
Sponsors:	N. Todd | K. Priola / D. Esgar | L. Landgraf
Summary:	**Sections 1 to 14** of the bill require podiatrists, physicians, physician assistants, advanced practice nurses, and optometrists, starting July 1, 2021, and dentists and practitioners serving rural communities or in a solo practice, starting July 1, 2023, to prescribe schedule II, III, or IV controlled substances only via a prescription that is electronically transmitted to a pharmacy unless a specified exception applies. Prescribers are required to indicate on license renewal questionnaires whether they have complied with the electronic prescribing requirement.

Section 15 specifies that pharmacists need not verify the applicability of an exception to electronic prescribing when they receive an order for a controlled substance in writing, orally, or via facsimile transmission and may fill the order if otherwise valid under the law.
(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/14/2019 Introduced In Senate - Assigned to Business, Labor, & Technology
2/4/2019 Senate Committee on Business, Labor, & Technology Refer Amended - Consent Calendar to Senate Committee of the Whole
2/6/2019 Senate Second Reading Special Order - Passed with Amendments - Committee
2/7/2019 Senate Third Reading Passed - No Amendments
2/8/2019 Introduced In House - Assigned to Public Health Care & Human Services
3/6/2019 House Committee on Public Health Care & Human Services Refer Amended to House Committee of the Whole

Date Introduced: 2019-01-14

SB19-134 Out-of-network Health Care Disclosures And Charges

Comment: **Priority 1**

Position: **Neutral**

Calendar Notification: NOT ON CALENDAR

Short Title: Out-of-network Health Care Disclosures And Charges

Sponsors: R. Fields | J. Tate / M. Soper

Summary: The bill:

- ★ Sets the reimbursement rate that a health insurance carrier must pay a health care facility if a covered person is treated for emergency services;
- ★ Requires in-network health care facilities and health care providers to make disclosures to patients covered by a health benefit plan concerning the provision of services by an out-of-network provider;
- ★ Outlines the claims and payment process, including reimbursement rates for the provision of out-of-network services for health care facilities and health care providers; and
- ★ Authorizes arbitration for the payment of health care claims that are in dispute if certain criteria are met.

The commissioner of insurance is required to submit a report annually to the general assembly concerning unanticipated out-of-network services.

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

Status: 2/7/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-02-07

Health District
OF NORTHERN LARIMER COUNTY

Priority 2 Bills

3/8/2018

HB19-1017	**Kindergarten Through Fifth Grade Social And Emotional Health Act**
Comment:	**Priority 2**
Position:	
Calendar Notification:	NOT ON CALENDAR
Short Title:	Kindergarten Through Fifth Grade Social And Emotional Health Act
Sponsors:	D. Michaelson Jenet / R. Fields
Summary:	The bill creates the "Colorado K-5 Social and Emotional Health Act" (act). The act requires the department of education (department) to select a pilot school district (pilot district) to participate in a pilot program that ensures that a school social worker, as defined in the act, is dedicated to each of grades kindergarten through fifth grade. To the extent possible, the school social worker shall follow the same students through each grade. The general assembly shall appropriate the resources necessary for the pilot district to hire or contract with the additional school social workers. The department shall select a pilot district that meets the characteristics outlined in the bill, including high poverty, ethnic diversity, and a large concentration of students in the foster care system. Among other responsibilities consistent with the school social worker license, the school social worker shall provide needed services to students and their families in the pilot district, including identifying learning disabilities, conducting functional behavior assessments and developing behavior intervention plans, identifying food insecurities, and helping eligible students and their families access public benefits. Services must be provided at school and during school hours, as appropriate. The pilot program begins operation during the 2020-21 school year and repeals in July 2027. The department shall contract with a professional program evaluator (evaluator) to conduct a preliminary evaluation in 2024 and a final evaluation before the repeal of the pilot program. The evaluator shall establish the method for the pilot district's data collection and monitor data throughout the pilot program. The evaluator shall evaluate the effectiveness of services provided by the pilot program on the academic, mental, and physical health and well-being of the student cohorts within the scope of the pilot program. The bill requires the department to request money for pilot program administration, employment contracts for social workers, and the pilot program evaluation through the annual budget process. *(Note: This summary applies to this bill as introduced.)*
Status:	1/4/2019 Introduced In House - Assigned to Education + Appropriations 2/14/2019 House Committee on Education Refer Amended to Appropriations

Date Introduced: 2019-01-04

Amendments: Amendments

HB19-1021 Repeal Ammunition Magazine Prohibition

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Repeal Ammunition Magazine Prohibition

Sponsors: L. Saine | S. Humphrey

Summary: The bill repeals statutory provisions:

- Prohibiting the possession of certain ammunition magazines; and
- Requiring each of certain ammunition magazines that are manufactured in Colorado on or after July 1, 2013, to include a permanent stamp or marking indicating that the magazine was manufactured or assembled after July 1, 2013.

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

Status: 1/4/2019 Introduced In House - Assigned to State, Veterans, & Military Affairs
1/24/2019 House Committee on State, Veterans, & Military Affairs Postpone Indefinitely

Date Introduced: 2019-01-04

Amendments:

HB19-1028 Medical Marijuana Condition Autism

Comment: **Priority 2**

Position:

Calendar Notification: Thursday, March 14 2019
SENATE HEALTH & HUMAN SERVICES COMMITTEE
1:30 PM LSB-B
(1) in senate calendar.

Short Title: Medical Marijuana Condition Autism

Sponsors: E. Hooton | K. Ransom / D. Coram | S. Fenberg

Summary: The bill adds autism spectrum disorders to the list of disabling medical conditions that authorize a person to use medical marijuana for his or her condition. Under current law, a child under 18 years of age who wants to be added to the medical marijuana registry for a disabling medical condition must be diagnosed as having a disabling medical condition by 2 physicians, one of whom must be a board-certified pediatrician, a board-certified family physician, or a board-certified child and adolescent psychiatrist who attests that he or she is part of the patient's primary care provider team. The bill removes the additional requirements on specific physicians to align with the constitutional provisions for a debilitating medical condition. The bill states if the recommending physician is not the patient's primary care physician, the recommending physician shall review the records of a diagnosing physician or a licensed mental health provider acting within its scope of practice.

The bill encourages the state board of health, when awarding marijuana study grants, to prioritize grants to gather objective scientific research regarding the efficacy and the safety of administering medical marijuana for pediatric conditions, including but not limited to autism spectrum disorder.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/4/2019 Introduced In House - Assigned to Health & Insurance
1/23/2019 House Committee on Health & Insurance Refer Unamended to House Committee of the Whole
1/25/2019 House Second Reading Passed - No Amendments
1/28/2019 House Third Reading Laid Over to 01/30/2019 - No Amendments
1/30/2019 House Third Reading Laid Over Daily - No Amendments
2/6/2019 House Third Reading Re-referred to House Committee of the Whole - No Amendments
2/6/2019 House Second Reading Passed with Amendments - Floor
2/7/2019 House Third Reading Passed - No Amendments
2/11/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-04

Amendments: Amendments

HB19-1032 Comprehensive Human Sexuality Education

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Comprehensive Human Sexuality Education

Sponsors: S. Lontine | Y. Caraveo / N. Todd | D. Coram

Summary: The bill moves provisions of the statutory legislative declaration to a nonstatutory legislative declaration.

The bill clarifies content requirements for public schools that offer comprehensive human sexuality education and prohibits instruction from explicitly or implicitly teaching or endorsing religious ideology or sectarian tenets or doctrines, using shame-based or stigmatizing language or instructional tools, employing gender norms or gender stereotypes, or excluding the relational or sexual experiences of lesbian, gay, bisexual, or transgender individuals.

Current law provides for a comprehensive human sexuality education grant program. The bill amends certain provisions of the grant program to:

- Require the department of public health and environment to submit an annual report concerning the outcomes of the grant program indefinitely;
- Add 8 representatives to the oversight entity and require membership of the oversight entity to be comprised of at least 7 members who are members of groups of people who have been or might be discriminated against;
- Require grant applicants to demonstrate a need for money to implement comprehensive human sexuality education; and
- Require that rural public schools or public schools that do not currently offer comprehensive human sexuality education receive priority when selecting grant applicants.

The bill provides a general appropriation of at least $1 million annually for the grant program.

The bill prohibits the state board of education from waiving the content requirements for any public school that provides comprehensive human sexuality education.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status:
1/4/2019 Introduced In House - Assigned to Health & Insurance
1/30/2019 House Committee on Health & Insurance Refer Amended to Appropriations
2/12/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole
2/14/2019 House Second Reading Laid Over Daily - No Amendments
2/15/2019 House Second Reading Passed with Amendments - Committee, Floor
2/19/2019 House Third Reading Passed - No Amendments
2/21/2019 Introduced In Senate - Assigned to Health & Human Services
2/28/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-04

Amendments: Amendments

HB19-1036 Annual Stipends For Certified School Professionals

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Annual Stipends For Certified School Professionals

Sponsors: J. Arndt | B. McLachlan / N. Todd

Summary: The bill adds nationally certified school psychologists as school professionals eligible for annual stipends awarded by the department of education (department) if the school psychologist meets the requirements set forth in the bill.

The bill clarifies that school counselors, who hold a certification from the national board for certified counselors or from the national board for professional teaching standards, are school professionals who have been eligible for annual stipends awarded by the department since the initial award was distributed during the 2009-10 school year.

The bill corrects the name of the national board for professional teaching standards by removing the word "principal" from the title.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status:
1/4/2019 Introduced In House - Assigned to Education
1/22/2019 House Committee on Education Refer Amended to House Committee of the Whole
1/25/2019 House Second Reading Passed with Amendments - Committee
1/28/2019 House Third Reading Passed - No Amendments
1/29/2019 Introduced In Senate - Assigned to Education
2/7/2019 Senate Committee on Education Refer Unamended - Consent Calendar to Senate Committee of the Whole
2/12/2019 Senate Second Reading Laid Over Daily - No Amendments
2/13/2019 Senate Second Reading Passed - No Amendments
2/14/2019 Senate Third Reading Passed - No Amendments
2/14/2019 Senate Third Reading Reconsidered - No Amendments
2/20/2019 Signed by the Speaker of the House
2/21/2019 Sent to the Governor

	2/21/2019 Signed by the President of the Senate 2/28/2019 Governor Signed
Date Introduced:	2019-01-04
Amendments:	Amendments

HB19-1041 Require Surgical Smoke Protection Policies

Comment:	**Priority 2**
Position:	
Calendar Notification:	NOT ON CALENDAR
Short Title:	Require Surgical Smoke Protection Policies
Sponsors:	J. Buckner / R. Rodriguez
Summary:	The bill requires each hospital with surgical services and each ambulatory surgical center to adopt and implement on or before May 1, 2021, a policy that prevents human exposure to surgical smoke via the use of a surgical smoke evacuation system during any planned surgical procedure that is likely to generate surgical smoke. Surgical smoke is a gaseous by-product produced by energy-generating surgical medical devices. *(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)*
Status:	1/4/2019 Introduced In House - Assigned to Health & Insurance 1/22/2019 House Committee on Health & Insurance Refer Amended to House Committee of the Whole 1/25/2019 House Second Reading Passed with Amendments - Committee 1/25/2019 House Second Reading Passed with Amendments - Committee 1/28/2019 House Third Reading Passed - No Amendments 1/29/2019 Introduced In Senate - Assigned to Health & Human Services 3/7/2019 Senate Committee on Health & Human Services Refer Unamended - Consent Calendar to Senate Committee of the Whole
Date Introduced:	2019-01-04
Amendments:	Amendments

HB19-1049 Concealed Handguns On School Grounds

Comment:	**Priority 2**
Position:	
Calendar Notification:	NOT ON CALENDAR
Short Title:	Concealed Handguns On School Grounds
Sponsors:	P. Neville
Summary:	With certain exceptions, current law limits the authority of a person who holds a valid permit to carry a concealed handgun by prohibiting a permit holder from carrying a concealed handgun on public elementary, middle, junior high, or high school grounds. The bill removes this limitation.

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

Status: 1/4/2019 Introduced In House - Assigned to State, Veterans, & Military Affairs
1/24/2019 House Committee on State, Veterans, & Military Affairs Postpone Indefinitely

Date Introduced: 2019-01-04

Amendments:

HB19-1058 **Income Tax Benefits For Family Leave**

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Income Tax Benefits For Family Leave

Sponsors: L. Landgraf | S. Beckman / K. Priola

Summary: **Section 2** of the bill establishes leave savings accounts. A leave savings account is an account with a financial institution for which the individual uses money to pay for any expense while he or she is on eligible leave, which includes:

- The birth of a child of the individual and in order to care for the child;
- The placement of a child with the individual for adoption or foster care;
- Caring for a spouse, child, or parent of the individual if the spouse, child, or parent has a serious health condition;
- A serious health condition that makes the individual unable to perform the functions of the position of the individual; or
- Any qualifying exigency, as determined by the United States secretary of labor, arising out of the fact that a spouse, child, or parent of the individual is on covered active duty, or has been notified of an impending call or order to covered active duty, in the United States armed forces.

An individual may annually contribute up to $5,000 of state pretax wages to a leave savings account. Employers may also make a matching contribution to an employee's leave savings account. The department of revenue is required to establish a form about a leave savings account, and the individual must annually file this form to be eligible for the tax benefit.

Sections 3 and 4 allow an employee and an employer to claim a state income tax deduction for amounts they contribute to the employee's leave savings account. Section 3 also allows a taxpayer to deduct any interest or other income earned on the investment during the taxable year from their leave savings account.

Regardless of how the money is deposited in the leave savings account, if an individual uses money in the account for an unauthorized purpose, then the money is subject to recapture in the year it is withdrawn and to a penalty equal to 10% of the amount recaptured.

Section 5 creates an income tax credit for an employer that pays an employee for leave that is between 6 and 12 weeks long for one of the following reasons:

- The birth of a child of the employee and in order to care for the child;
- Placement of a child with the employee for adoption or foster care;
- Caring for a spouse, child, or parent of the employee if the spouse, child, or parent has a serious health condition;
- A serious health condition that makes the employee unable to perform the functions of the position of the employee; or
- Any qualifying exigency, as determined by the United States secretary of labor, arising out of the fact that a spouse, child, or parent of the employee is on covered active duty, or has been notified of an impending call or order to covered active duty, in the United States armed forces.

For employers with fewer than 50 employees, the credit is equal to 50% of the amount paid, and for employers with 50 or more employees it is equal to 25% of the amount paid. The credit is not refundable, but it may be carried forward up to 5 years.

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

Status: 1/4/2019 Introduced In House - Assigned to Finance
1/31/2019 House Committee on Finance Postpone Indefinitely

Date Introduced: 2019-01-04

Amendments:

HB19-1087 Local Public Meeting Notices Posted On Website

Comment: **Priority 2**

Position:

Calendar Notification: Wednesday, March 13 2019
Transportation & Local Government
1:30 p.m. Room 0112
(1) in house calendar.

Short Title: Local Public Meeting Notices Posted On Website

Sponsors: M. Soper | C. Hansen / R. Woodward

Summary: The bill requires a local government to post notices of public meetings required by the state open meetings law on the local government's website. The notices are accessible to the public at no charge. The notices shall be searchable, if feasible, by type of meeting, date and time of meeting, and agenda contents.

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

Status: 1/14/2019 Introduced In House - Assigned to Transportation & Local Government

Date Introduced: 2019-01-14

Amendments:

HB19-1089 Exemption From Garnishment For Medical Debt

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Exemption From Garnishment For Medical Debt

Sponsors: K. Tipper | A. Valdez / B. Pettersen | D. Moreno

Summary: The bill exempts a person's earnings from garnishment if the person's family income does not exceed 400% of current federal poverty guidelines and the

judgment is for medical debt. A writ of continuing garnishment must include notice that a person's earnings may be exempt if those criteria are met, notice of the judgment debtor's right to object and have a hearing on that objection, and a statement that, to the best of the judgment creditor's knowledge, the judgment debtor's earnings are not exempt.

The bill takes effect on January 1, 2020, and applies to judgments entered on or after that date.

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

Status: 1/14/2019 Introduced In House - Assigned to Finance
2/4/2019 House Committee on Finance Postpone Indefinitely

Date Introduced: 2019-01-14

Amendments:

HB19-1095 **Physician Assistants Supervision And Liability**

Comment: **Priority 2/3**

Position:

Calendar Notification: Friday, March 8 2019
Appropriations
8:00 a.m. Room LSB-A
(2) in house calendar.

Short Title: Physician Assistants Supervision And Liability

Sponsors: L. Cutter | L. Landgraf / R. Fields

Summary: The bill establishes supervisory requirements for physician assistants who:

- Have practiced for less than 3 years;
- Have practiced for 3 years or more; or
- Have practiced for at least 12 months and are making a substantive change in their scope of practice or practice area.

Current law states that a licensed physician may be responsible for the direction and supervision of up to 4 physician assistants at any one time and may be responsible for the direction and supervision of more than 4 physician assistants upon receiving specific approval from the Colorado medical board (board). The bill eliminates this restriction.

The bill adds 2 more physician assistants as members of the board, for a total of 3 physician assistant members. Current law requires the president of the board to establish a licensing panel consisting of 3 members of the board. The bill adds a fourth member to the licensing panel; that is, a person who is a physician assistant member of the board.

The bill states that a physician assistant who has practiced for at least 3 years may be liable for damages resulting from negligence in providing care to a patient; except that a physician assistant is not liable for any such damages that occur as a result of the physician assistant following a direct order from a supervising physician.

Current law requires that when persons licensed to practice medicine form professional service corporations for the practice of medicine, the articles of incorporation of such corporations must state that one or more licensed physician assistants may be a shareholder of the corporation as long as the physician shareholders maintain majority ownership of the corporation. The bill removes this requirement.

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

Status: 1/14/2019 Introduced In House - Assigned to Health & Insurance
2/19/2019 House Committee on Health & Insurance Refer Amended to Appropriations
3/8/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole

Date Introduced: 2019-01-14

Amendments:

HB19-1109 Convalescent Centers As Pharmacies

Comment: **Priority 2/3**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Convalescent Centers As Pharmacies

Sponsors: E. Hooton | C. Larson / B. Pettersen | J. Tate

Summary: The bill allows licensed convalescent centers to procure, store, order, dispense, and administer prescription medications.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/14/2019 Introduced In House - Assigned to Public Health Care & Human Services
2/1/2019 House Committee on Public Health Care & Human Services Refer Unamended to House Committee of the Whole
2/5/2019 House Second Reading Laid Over to 02/12/2019 - No Amendments
2/11/2019 House Second Reading Special Order - Passed with Amendments - Floor
2/12/2019 House Third Reading Passed - No Amendments
2/12/2019 Introduced In Senate - Assigned to Health & Human Services
2/20/2019 Senate Committee on Health & Human Services Refer Unamended - Consent Calendar to Senate Committee of the Whole
2/25/2019 Senate Second Reading Passed - No Amendments
2/26/2019 Senate Third Reading Passed - No Amendments
3/1/2019 Sent to the Governor
3/1/2019 Signed by the President of the Senate
3/1/2019 Signed by the Speaker of the House

Date Introduced: 2019-01-14

Amendments: Amendments

HB19-1117 Regulation Of Professions And Occupations Reform

Comment: **Priority 2**

Position:

Calendar NOT ON CALENDAR

Notification:

Short Title: Regulation Of Professions And Occupations Reform

Sponsors: S. Sandridge

Summary: Current law requires the department of regulatory agencies to analyze whether to begin or continue the regulation of a profession or occupation based on several factors. The bill elaborates on these factors and requires the department to find a present, significant, and substantiated harm to consumers before recommending regulation. The bill further requires the department to recommend only the least restrictive regulation necessary to address the harm and sets guidelines for recommended regulation.
(Note: This summary applies to this bill as introduced.)

Status: 1/16/2019 Introduced In House - Assigned to Business Affairs and Labor + Appropriations
1/16/2019 Introduced In House - Assigned to Business Affairs & Labor + Appropriations
2/13/2019 House Committee on Business Affairs & Labor Postpone Indefinitely

Date Introduced: 2019-01-16

Amendments:

HB19-1122 Colorado Department Of Public Health And Environment Maternal Mortality Review Committee

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Colorado Department Of Public Health And Environment Maternal Mortality Review Committee

Sponsors: J. Buckner | L. Landgraf / R. Fields | B. Gardner

Summary: The bill creates the Colorado maternal mortality review committee (committee), which is required to review maternal deaths, identify the causes of maternal mortality, and develop recommendations to address preventable maternal deaths, including legislation, policies, rules, and best practices that will support the health and safety of the pregnant and postpartum population in Colorado and prevent maternal deaths. The chief medical officer of the department of public health and environment (department) is directed to appoint at least 11 members to serve on the committee.

The bill requires certain health care providers and law enforcement officials to provide medical records to the department concerning each maternal death for access by the members of the committee. The records, notes, information, and activities of the committee are confidential.

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

Status: 1/16/2019 Introduced In House - Assigned to Public Health Care & Human Services
2/13/2019 House Committee on Public Health Care & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-16

Amendments: Amendments

HB19-1145 Primary Residence Exempt Liens For Medical Debt

Comment: **Priority 2**

Position:

Calendar Notification: Monday, March 11 2019
Finance
1:30 p.m. Room LSB-A
(1) in house calendar.

Short Title: Primary Residence Exempt Liens For Medical Debt

Sponsors: K. Tipper | S. Jaquez Lewis

Summary: The bill exempts a person's primary residence from attachment or execution of a lien as the result of a judgment for medical debt. A person recording a transcript of judgment must record an affidavit with the transcript stating that the signer is an authorized agent of the judgment creditor and whether the judgment is for medical debt. A judgment debtor may record an affidavit with the county stating the debtor's name, a description of the debtor's interest in the property, and that the property is the debtor's primary residence. A primary residence is defined as a person's dwelling place and includes the dwelling, the lot or lots on which the dwelling is situated, including a farm of any number of acres, and any appurtenances.

The bill takes effect on January 1, 2020, and applies to judgments entered on or after that date.

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

Status: 1/29/2019 Introduced In House - Assigned to Finance

Date Introduced: 2019-01-29

Amendments:

HB19-1150 Recreate Consumer Insurance Council

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Recreate Consumer Insurance Council

Sponsors: B. Titone / J. Danielson

Summary: The consumer insurance council, which was an advisory body appointed by the commissioner of insurance to provide advice to the commissioner on insurance matters of interest to the public, was created in 2008 and sunsetted on July 1, 2018.

The bill recreates and reenacts the consumer insurance council and its duties and responsibilities, as they existed on June 30, 2018, with the following modifications:

- The council's authority to issue annual consumers' choice awards to health insurers is not reenacted;
- The council is to consist of at least 6 members and not more than 15 members, consumers not engaged in the insurance industry may serve on the council, the council is to reflect the state's demographic diversity in addition to geographic diversity but need not include representation from each congressional district in the state, and the commissioner is to timely appoint members to the council;
- Members are to be reimbursed for actual and necessary expenses incurred in traveling to and from council meetings, including any required dependent care and dependent or attendant travel, food, and lodging expenses;
- The council is to meet quarterly and may request to meet up to 4 more times per year; and

★ The council is authorized to submit recommendations to the commissioner, and the commissioner is required to timely respond to council recommendations.

The council is scheduled for sunset review and repeal on September 1, 2029.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/29/2019 Introduced In House - Assigned to Health & Insurance
2/13/2019 House Committee on Health & Insurance Refer Amended to Appropriations
2/28/2019 House Committee on Appropriations Refer Unamended to House Committee of the Whole
3/1/2019 House Second Reading Laid Over Daily - No Amendments
3/5/2019 House Second Reading Passed with Amendments - Committee
3/6/2019 House Third Reading Passed - No Amendments
3/7/2019 Introduced In Senate - Assigned to Health & Human Services

Date Introduced: 2019-01-29

Amendments: Amendments

HB19-1161 Comprehensive Physical Education Instruction Pilot

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Comprehensive Physical Education Instruction Pilot

Sponsors: J. Buckner | J. Wilson / N. Todd | K. Priola

Summary: The bill creates the health and wellness through comprehensive quality physical education instruction pilot program (pilot program) in the department of education (department).

The purpose of the pilot program is to allow a school or a school district, as defined in the bill, serving any of grades K-8, to apply for grant money to implement a pilot program in a school or in schools of a school district. The pilot program must be implemented in all K-8 grades in the school or school district.

Pilot program grants are for 3 academic years and are awarded to at least 15 but not more than 30 eligible schools or school districts for a total of not more than $3 million awarded annually, including department administrative expenses. Pilot program grants are awarded in February prior to the first academic year to allow grantees to create a 3-year plan for the use of the grant money.

The bill includes application deadlines and criteria for the award of grants. The department will review grant applications and make recommendations to the state board of education for the award of the pilot program grants.

Grant money awarded through the pilot program can be used only to implement comprehensive quality physical education instruction, as described in the bill. The bill lists the components that must be included in a comprehensive quality physical education instruction program.

The department shall contract with a program evaluator for purposes of completing a program evaluation of the pilot program at the end of the 3-year grant period. The bill lists program evaluation criteria. First priority shall be given to a vendor proposal from a state-supported institution of higher education that has the expertise necessary to assess the impact of the pilot program.

The bill requires annual reporting to the education committees of the senate and the house of representatives.

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

Status: 1/30/2019 Introduced In House - Assigned to Education + Appropriations
3/7/2019 House Committee on Education Refer Amended to Appropriations

Date Introduced: 2019-01-30

Amendments:

HB19-1164 Child Tax Credit

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Child Tax Credit

Sponsors: J. Singer / R. Zenzinger | K. Priola

Summary: In 2013, the general assembly created a child tax credit against state income taxes for a resident individual. But the credit, which is a percentage of the federal child tax credit based on the taxpayer's income, is only allowed after the United States congress enacts a version of the "Marketplace Fairness Act".

The bill repeals the contingent start of the tax credit and instead allows the credit to be claimed for any income tax year beginning with the 2019 income tax year.

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

Status: 1/30/2019 Introduced In House - Assigned to Finance + Appropriations
2/25/2019 House Committee on Finance Refer Amended to Appropriations

Date Introduced: 2019-01-30

Amendments: Amendments

HB19-1177 Extreme Risk Protection Orders

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Extreme Risk Protection Orders

Sponsors: T. Sullivan | A. Garnett / L. Court | B. Pettersen

Summary: The bill creates the ability for a family or household member or a law enforcement officer to petition the court for a temporary extreme risk protection order (ERPO) beginning January 1, 2020. The petitioner must establish by a preponderance of the evidence that a person poses a significant risk to self or others by having a firearm in his or her custody or control or by possessing, purchasing, or receiving a firearm. The petitioner must submit an affidavit

signed under oath and penalty of perjury that sets forth facts to support the issuance of a temporary ERPO and a reasonable basis for believing they exist. The court must hold a temporary ERPO hearing in person or by telephone on the day the petition is filed or on the court day immediately following the day the petition is filed.

After issuance of a temporary ERPO, the court must schedule a second hearing no later than 14 days following the issuance to determine whether the issuance of a continuing ERPO is warranted. The court shall appoint counsel to represent the respondent at the hearing. If a family or household member or a law enforcement officer establishes by clear and convincing evidence that a person poses a significant risk to self or others by having a firearm in his or her custody or control or by possessing, purchasing, or receiving a firearm, the court may issue a continuing ERPO. The ERPO prohibits the respondent from possessing, controlling, purchasing, or receiving a firearm for 364 days.

Upon issuance of the ERPO, the respondent shall surrender all of his or her firearms and his or her concealed carry permit if the respondent has one. The respondent may surrender his or her firearms either to a law enforcement agency or a federally licensed firearms dealer, or, if the firearm is an antique or relic or curio, the firearm may be surrendered to a family member who is eligible to possess a firearm and who does not reside with the respondent. If a person other than the respondent claims title to any firearms surrendered to law enforcement, the firearm shall be returned to him or her.

The respondent can motion the court once during the 364-day ERPO for a hearing to terminate the ERPO. The respondent has the burden of proof at a termination hearing. The court shall terminate the ERPO if the respondent establishes by clear and convincing evidence that he or she no longer poses a significant risk of causing personal injury to self or others by having in his or her custody or control a firearm or by purchasing, possessing, or receiving a firearm. The court may continue the hearing if the court cannot issue an order for termination at that time but believes there is a strong possibility the court could issue a termination order prior to the expiration of the ERPO.

The petitioner requesting the original ERPO may request an extension of the ERPO before it expires. The petitioner must show by clear and convincing evidence that the respondent continues to pose a significant risk of causing personal injury to self or others by having a firearm in his or her custody or control or by purchasing, possessing, or receiving a firearm. If the ERPO expires or is terminated, all of the respondent's firearms must be returned within 3 days of the respondent requesting return.

The bill provides a respondent who had a malicious or false petition for a temporary extreme risk protection order or extreme risk protection order filed against him or her with a private cause of action against the petitioner. In the action, the plaintiff is entitled to actual damages, attorney fees, and costs.

The bill requires the state court administrator to develop and prepare standard petitions and ERPO forms. Additionally, the state court administrator at the judicial department's "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing shall provide statistics related to petitions for ERPOs.

The bill appropriates $119,392 from the general fund to the judicial department for court costs and court-appointed counsel costs.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 2/14/2019 Introduced In House - Assigned to Judiciary
2/21/2019 House Committee on Judiciary Refer Amended to Appropriations
2/28/2019 House Committee on Appropriations Refer Amended to House Committee of the Whole
3/1/2019 House Second Reading Passed with Amendments - Committee, Floor
3/4/2019 House Third Reading Passed - No Amendments
3/7/2019 Introduced In Senate - Assigned to State, Veterans, & Military Affairs

Date Introduced: 2019-02-14

Amendments: Amendments

HB19-1183 Automated External Defibrillators In Public Places

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Automated External Defibrillators In Public Places

Sponsors: D. Roberts

Summary: The bill defines a public place and encourages any person that owns, operates, or manages a public place to place functional automated external defibrillators (AEDs) in sufficient quantities to ensure reasonable availability for use during perceived sudden cardiac arrest emergencies.

The bill requires any public place to accept any gift, grant, or donation of an AED that meets federal standards.

The department shall award a $75,000 contract to a nonprofit organization for the purpose of acquiring and distributing AEDs to public places.

The bill extends good samaritan protections to a variety of persons and entities.

The bill repeals an obsolete provision that encouraged school districts to acquire an AED and moves that provision to article 51 of title 25. The bill also repeals an obsolete provision that provided limited immunity to persons rendering emergency assistance through the use of an AED.

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

Status: 2/14/2019 Introduced In House - Assigned to Health & Insurance
3/6/2019 House Committee on Health & Insurance Refer Amended to Appropriations

Date Introduced: 2019-02-14

Amendments: Amendments

HB19-1184 Demographic Notes For Certain Legislative Bills

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Demographic Notes For Certain Legislative Bills

Sponsors: L. Herod | Y. Caraveo

Summary: The bill requires the staff of the legislative council to prepare demographic notes on legislative bills in each regular session of the general assembly. The speaker of the house of representatives, the minority leader of the house of representatives, the president of the senate, and the minority leader of the senate are authorized to request 5 demographic notes each, or more at the discretion of the director of research of the legislative council.

The bill requires the staff of the legislative council to meet with the member of leadership requesting the demographic note and with the sponsor of the legislative bill to discuss whether a demographic note can practically be completed for that legislative bill. If not, the member of leadership may request a demographic note, within the limits specified in the bill, on a different legislative bill that might be more conducive to a demographic note's analysis.

A demographic note is defined as a note that uses available data to outline the potential disparate effects of a legislative measure on various populations within the state. Populations may be identified by race, gender, disability, age, geography, income, or any other relevant characteristic for which data are available.

The bill requires the director of research of the legislative council to develop the procedures for requesting, completing, and updating the demographic notes and to memorialize the procedures in a letter to the executive committee of the legislative council.

Finally, the bill requires each state department, agency, or institution to cooperate with and provide information for a demographic note of a legislative bill in the manner requested by the staff of the legislative council.

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

Status: 2/15/2019 Introduced In House - Assigned to Finance
3/4/2019 House Committee on Finance Refer Amended to Appropriations

Date Introduced: 2019-02-15

Amendments: Amendments

HB19-1189 **Wage Garnishment Reform**

Comment: **Priority 2**

Position:

Calendar Notification: Monday, March 11 2019
Finance
1:30 p.m. Room LSB-A
(4) in house calendar.

Short Title: Wage Garnishment Reform

Sponsors: M. Gray | A. Valdez / J. Bridges

Summary: Under current law, the amount of an individual's disposable earnings subject to garnishment is either 25% of the individual's disposable earnings for a week or the amount an individual's disposable earnings for a week exceed 30 times the state or federal minimum wage, whichever is less. The bill changes the amount subject to garnishment from 25% to 15% of the individual's disposable weekly earnings and from 30 times to 50 times the amount an individual's disposable earnings for a week exceed the state or federal minimum wage. Currently, the cost of court-ordered health insurance for a child provided by an individual is deducted from the individual's disposable earnings subject to garnishment. The bill also deducts from an individual's disposable earnings subject to garnishment the cost of any health insurance that is provided by the individual's employer and voluntarily withheld from the individual's earnings.

The bill creates an exemption that would permit individuals to prove that the amount of their pay subject to garnishment should be further reduced or eliminated altogether if the individual can establish that such reductions are necessary to support the individual or the individual's family. The bill also requires clearer and more timely notice to an individual whose wages are being garnished and gives the individual more time after receiving the notice before garnishment starts.

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

Status: 2/19/2019 Introduced In House - Assigned to Finance

Date Introduced: 2019-02-19

Amendments:

HB19-1203 School Nurse Grant Program

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: School Nurse Grant Program

Sponsors: K. Mullica / N. Todd

Summary: The bill creates the school nurse grant program (grant program) in the department of public health and environment (department).

The grant program awards grants to local education providers, as defined in the bill, to hire school nurses to serve in public schools. Grants are awarded on a 5-year grant cycle, with an initial one-year grant, renewable for an additional 4 years, as long as there is a school nurse in the grant-funded position and the grant money is being used for authorized purposes.

Subject to annual appropriations from the general assembly, the department shall recommend grant recipients, and the state board of health shall annually award up to $3 million during the 5-year grant cycle. Once the 5-year grant cycle is complete, the department shall administer a new grant cycle.

The department may expend a portion of the grant money for reasonable and necessary administrative expenses.

In each year in which school nurse grants are awarded, the department shall report to certain committees of the general assembly concerning the grant program.

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

Status: 2/20/2019 Introduced In House - Assigned to Education + Appropriations
3/5/2019 House Committee on Education Refer Amended to Appropriations

Date Introduced: 2019-02-21

Amendments: Amendments

HB19-1210 Local Government Minimum Wage

Comment: **Priority 2**

Position:

Calendar Notification: Friday, March 8 2019
GENERAL ORDERS - SECOND READING OF BILLS
(9) in house calendar.

Short Title: Local Government Minimum Wage

Sponsors: J. Melton | R. Galindo / J. Danielson | D. Moreno

Summary: The bill allows a unit of local government to enact laws establishing a minimum wage within its jurisdiction.

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

Status: 2/25/2019 Introduced In House - Assigned to Transportation & Local Government

3/6/2019 House Committee on Transportation & Local Government Refer Amended to House Committee of the Whole

Date Introduced: 2019-02-25

Amendments: Amendments

SB19-001 Expand Medication-assisted Treatment Pilot Program

Comment: **Priority 2**

Position:

Calendar Notification: Friday, March 8 2019
SENATE APPROPRIATIONS COMMITTEE
7:30 AM LSB-B
(1) in senate calendar.

Short Title: Expand Medication-assisted Treatment Pilot Program

Sponsors: L. Garcia

Summary: In 2017, the general assembly enacted Senate Bill 17-074, which created a 2-year medication-assisted treatment (MAT) expansion pilot program, administered by the university of Colorado college of nursing, to expand access to medication-assisted treatment to opioid-dependent patients in Pueblo and Routt counties. The 2017 act directs the general assembly to appropriate $500,000 per year for the 2017-18 and 2018-19 fiscal years from the marijuana tax cash fund to the university of Colorado board of regents, for allocation to the college of nursing to implement the pilot program. The pilot program repeals on June 30, 2020.

The bill:

- ★ Expands the pilot program to the counties in the San Luis valley and 2 additional counties in which a need is demonstrated;
- ★ Shifts responsibility to administer the pilot program from the college of nursing to the center for research into substance use disorder prevention, treatment, and recovery support strategies;
- ★ Adds representatives from the San Luis valley and any other counties selected to participate in the pilot program to the advisory board that assists in administering the program;
- ★ Increases the annual appropriation for the pilot program to $5 million for the 2019-20 and 2020-21 fiscal years; and
- ★ Extends the program an additional 2 years.

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

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
2/7/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations
3/8/2019 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole

Date Introduced: 2019-01-04

Amendments: Amendments

SB19-013 Medical Marijuana Condition Opiates Prescribed For

Comment: **Priority 2**

Position:

Calendar NOT ON CALENDAR

Notification:

Short Title: Medical Marijuana Condition Opiates Prescribed For

Sponsors: V. Marble | J. Ginal / E. Hooton | K. Ransom

Summary: The bill adds a condition for which a physician could prescribe an opiate to the list of disabling medical conditions that authorize a person to use medical marijuana for his or her condition. Under current law, a child under 18 years of age who wants to be added to the medical marijuana registry for a disabling medical condition must be diagnosed as having a disabling medical condition by 2 physicians, one of whom must be a board-certified pediatrician, a board-certified family physician, or a board-certified child and adolescent psychiatrist who attests that he or she is part of the patient's primary care provider team. The bill removes the additional requirements on specific physicians to align with the constitutional provisions for a debilitating medical condition. The bill states if the recommending physician is not the patient's primary care physician, the recommending physician shall review the records of a diagnosing physician or a licensed mental health provider acting within its scope of practice. The bill limits a patient with a disabling medical condition who is under eighteen years of age to using medical marijuana only in a nonsmokeable form when using medical marijuana upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/4/2019 Introduced In Senate - Assigned to Health & Human Services
2/6/2019 Senate Committee on Health & Human Services Refer Amended to Senate Committee of the Whole
2/11/2019 Senate Second Reading Passed with Amendments - Committee
2/12/2019 Senate Third Reading Passed - No Amendments
2/14/2019 Introduced In House - Assigned to Health & Insurance
3/6/2019 House Committee on Health & Insurance Witness Testimony and/or Committee Discussion Only

Date Introduced: 2019-01-04

Amendments: Amendments

SB19-052 Emergency Medical Service Provider Scope Of Practice

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Emergency Medical Service Provider Scope Of Practice

Sponsors: L. Garcia

Summary: Emergency medical service (EMS) providers are authorized to practice under the medical direction of a physician. **Section 1** of the bill expands an EMS provider's scope of practice by authorizing a provider to practice under the medical direction of an advanced practice nurse or a physician assistant.

Section 1 also:

- ★ Specifies that a provider may practice in a hospital or clinic; and
- ★ Authorizes the state board of health to promulgate rules to authorize other types of medical professionals to provide medical direction to EMS providers or to allow EMS providers to practice in other types of licensed health care facilities or health care-related settings.

Section 3 adds an advanced practice nurse and a physician assistant to the membership of the emergency medical practice advisory council and requires the governor to make initial appointments of the additional advisory council members on or before November 1, 2019.

Sections 2, 4, and 5 make conforming amendments.
(Note: This summary applies to this bill as introduced.)

Status: 1/8/2019 Introduced In Senate - Assigned to Health & Human Services
3/7/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-08

Amendments:

SB19-063 Infant And Family Child Care Action Plan

Comment: **Priority 2**

Position:

Calendar Notification: Wednesday, March 13 2019
Public Health Care & Human Services
Upon Adjournment Room 0107
(2) in house calendar.

Short Title: Infant And Family Child Care Action Plan

Sponsors: K. Priola | T. Story / B. Buentello | A. Valdez

Summary: The bill requires the department of human services (department), in consultation with the early childhood leadership commission (commission) and various stakeholders, to draft a strategic action plan addressing the declining availability of family child care homes and infant child care.

The bill requires the department to submit the completed strategic action plan to the commission; the state board of human services; the joint budget committee; the health and human services and education committees of the senate, or any successor committees; and the public health care and human services and education committees of the house of representatives, or any successor committees, no later than December 1, 2019.

The bill anticipates the department will receive $50,688 in federal funds to implement this bill for the 2019-20 state fiscal year.

(Note: This summary applies to the reengrossed version of this bill as introduced in the second house.)

Status: 1/10/2019 Introduced In Senate - Assigned to Health & Human Services
1/24/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations
2/8/2019 Senate Committee on Appropriations Refer Amended - Consent Calendar to Senate Committee of the Whole
2/12/2019 Senate Second Reading Passed with Amendments - Committee
2/13/2019 Senate Third Reading Passed - No Amendments
2/14/2019 Introduced In House - Assigned to Public Health Care & Human Services

Date Introduced: 2019-01-10

Amendments: Amendments

SB19-073 Statewide System Of Advance Medical Directives

Comment: **Priority 2- The Board voted to Strongly Support SB19-073 but urged lawmakers to consider amendments that would encourage the connection of the registry to electronic health records, and not prohibiting others, besides the**

health provider, to upload directives to the registry.

Position: **Strongly Support**

Calendar Notification: NOT ON CALENDAR

Short Title: Statewide System Of Advance Medical Directives

Sponsors: J. Ginal / L. Landgraf

Summary: The bill requires the department of public health and environment (department) to create and administer a statewide electronic system (system) that allows qualified individuals to upload and access advance medical directives.

The bill defines an advance medical directive as a directive concerning medical orders for scope of treatment and requires the department to contract with one or more health information organization networks for the administration and maintenance of the system. The bill also requires the department to promulgate rules to administer the system.

The bill clarifies that it is the responsibility of the adult whose medical treatment is the subject of the advance medical directive, or the authorized surrogate decision-maker, to ensure that the advance medical directive uploaded to the system is current and accurate.

The bill does not allow for any civil or criminal liability or regulatory sanctions for any emergency personnel, health care provider, health care facility, or any other person that complies with a legally executed advance medical directive that is accessed from the system.

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

Status: 1/10/2019 Introduced In Senate - Assigned to Health & Human Services
2/6/2019 Senate Committee on Health & Human Services Refer Amended to Appropriations

Date Introduced: 2019-01-10

Amendments: Amendments

SB19-096 Collect Long-term Climate Change Data

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Collect Long-term Climate Change Data

Sponsors: K. Donovan / C. Hansen

Summary: The bill requires the air quality control commission in the department of public health and environment to collect greenhouse gas emissions data from greenhouse gas-emitting entities, report on the data, including a forecast of future emissions, and propose a draft rule to address the emissions by July 1, 2020.
(Note: This summary applies to this bill as introduced.)

Status: 1/23/2019 Introduced In Senate - Assigned to Transportation & Energy

Date Introduced: 2019-01-24

Amendments:

SB19-098 Cost-based Reimbursement For Rural Hospitals

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Cost-based Reimbursement For Rural Hospitals

Sponsors: L. Crowder

Summary: The bill requires Colorado's program of medical assistance to pay rural critical access hospitals and sole community hospitals for outpatient hospital services pursuant to a cost-based reimbursement methodology using 100% of actual cost.

Prior to implementing the cost-based reimbursement methodology for outpatient hospital services, the department of health care policy and financing (state department) shall convene a stakeholder group consisting of representatives of the affected hospitals and other persons or entities to consult with the state department on the elements of the cost-based reimbursement methodology and its implementation.

The bill makes a conforming amendment.

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

Status: 1/23/2019 Introduced In Senate - Assigned to Finance + Appropriations
2/12/2019 Senate Committee on Finance Postpone Indefinitely

Date Introduced: 2019-01-24

Amendments:

SB19-133 Require License Practice Genetic Counseling

Comment: **Priority 2**

Position:

Calendar Notification: NOT ON CALENDAR

Short Title: Require License Practice Genetic Counseling

Sponsors: J. Ginal | N. Todd / D. Michaelson Jenet

Summary: The bill enacts the "Genetic Counselor Licensure Act". On and after June 1, 2020, a person cannot practice genetic counseling without being licensed by the director of the division of professions and occupations in the department of regulatory agencies. To be licensed, a person must have been certified by a national body, except that the director may issue a provisional license to a candidate for certification pursuant to requirements established by rule.

The bill gives title protection to genetic counselors and standard licensing, rule-making, and disciplinary powers to the director. Genetic counselors must have insurance. The bill repeals the act on September 1, 2026, subject to sunset review. Genetic counselors are subject to the mandatory disclosures of the "Michael Skolnik Medical Transparency Act of 2010".
(Note: This summary applies to this bill as introduced.)

Status:	2/5/2019 Introduced In Senate - Assigned to Health & Human Services 2/21/2019 Senate Committee on Health & Human Services Refer Amended to Finance 3/5/2019 Senate Committee on Finance Refer Unamended to Appropriations
Date Introduced:	2019-02-05
Amendments:	Amendments

SB19-139 More Colorado Road And Community Safety Act Offices

Comment:	**Priority 2**
Position:	
Calendar Notification:	Friday, March 8 2019 SENATE APPROPRIATIONS COMMITTEE 7:30 AM LSB-B (8) in senate calendar.
Short Title:	More Colorado Road And Community Safety Act Offices
Sponsors:	D. Coram | D. Moreno / R. Galindo | J. Singer
Summary:	Current law provides for the issuance of identification documents, such as driver's licenses, to people who are temporarily present or who are not lawfully present in Colorado. The bill requires the department of revenue to issue these documents at 10 or more offices geographically distributed throughout the state. *(Note: This summary applies to this bill as introduced.)*
Status:	2/12/2019 Introduced In Senate - Assigned to Finance 2/28/2019 Senate Committee on Finance Refer Amended to Appropriations 3/8/2019 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole
Date Introduced:	2019-02-12
Amendments:	Amendments

SB19-181 Protect Public Welfare Oil And Gas Operations

Comment:	**Priority 2**
Position:	
Calendar Notification:	Friday, March 8 2019 SENATE APPROPRIATIONS COMMITTEE 7:30 AM LSB-B (9) in senate calendar.
Short Title:	Protect Public Welfare Oil And Gas Operations
Sponsors:	S. Fenberg / K. Becker
Summary:	The bill enhances local governments' ability to protect public health, safety, and welfare and the environment by clarifying, reinforcing, and establishing their regulatory authority over the surface impacts of oil and gas development.

Current law specifies that local governments have so-called "House Bill 1041" powers, which are a type of land use authority over oil and gas mineral extraction areas, only if the Colorado oil and gas conservation commission (commission) has identified a specific area for designation. **Sections 1 and 2** of the bill repeal that limitation.

Section 3 directs the air quality control commission to adopt rules to:

- Require an oil and gas operator of an oil and gas facility to install continuous emission monitoring equipment at the facility to monitor for hazardous air pollutants as specified by the commission by rule, as well as for methane and volatile organic compounds; and
- Minimize emissions of methane and other hydrocarbons and nitrogen oxides from the entire oil and gas fuel cycle.

Section 4 clarifies that local governments have land use authority to regulate the siting of oil and gas locations and to regulate land use and surface impacts, including the ability to inspect oil and gas facilities; impose fines for leaks, spills, and emissions; and impose fees on operators or owners to cover the reasonably foreseeable direct and indirect costs of permitting and regulation and the costs of any monitoring and inspection program necessary to address the impacts of development and enforce local governmental requirements.

Section 5 repeals an exemption for oil and gas production from counties' authority to regulate noise.

The remaining substantive sections of the bill amend the "Oil and Gas Conservation Act" (Act). The legislative declaration for the Act states that it is in the public interest to "foster" the development of oil and gas resources in a manner "consistent" with the protection of public health, safety, and welfare, including protection of the environment and wildlife resources; this has been construed to impose a balancing test between fostering oil and gas development and protecting the public health, safety, and welfare. **Section 6** states that the public interest is to "regulate" oil and gas development to "protect" those values.

Currently, the Act defines "waste" to include a diminution in the quantity of oil or gas that ultimately may be produced. **Section 7** excludes from that definition the nonproduction of oil or gas as necessary to protect public health, safety, and welfare or the environment. Section 7 also repeals the requirement that the commission take into consideration cost-effectiveness and technical feasibility with regard to actions and decisions taken to minimize adverse impacts to wildlife resources.

The 9-member commission currently includes 3 members who must have substantial experience in the oil and gas industry and one member who must have training or experience in environmental or wildlife protection. **Section 8** reduces the number of industry members to one and requires one member with training or substantial experience in wildlife protection; one member with training or substantial experience in environmental protection; one member with training or substantial experience in soil conservation or reclamation; one member who is an active agricultural producer or a royalty owner; and one member with training or substantial experience in public health. **Section 9** requires the director of the commission to hire up to 2 deputy directors.

The Act currently specifies that the commission has exclusive authority relating to the conservation of oil or gas. **Section 10** clarifies that nothing in the Act alters, impairs, or negates the authority of:

- The air quality control commission to regulate the air pollution associated with oil and gas operations;
- The water quality control commission to regulate the discharge of water pollutants from oil and gas operations;
- The state board of health to regulate the disposal of naturally occurring radioactive materials and technologically enhanced naturally occurring radioactive materials from oil and gas operations;
- The solid and hazardous waste commission to regulate the disposal of hazardous waste and exploration and production waste from oil and gas operations; or
- A local government to regulate land use related to oil and gas operations, including specifically the siting of an oil and gas location.

Currently, an operator first gets a permit from the commission to drill one or more wells within a drilling unit, which is located within a defined area, and then notifies the applicable local government of the proposed development and seeks any necessary local government approval. **Section 11** requires operators to file, with the application for a permit to drill, either: Proof that the operator has already filed an application with the affected local government to approve the siting of the proposed oil and gas location and of the local government's disposition of the application; or proof that the affected local government does not regulate the siting of oil and gas locations. Section 11 also specifies that the commission and the director shall not issue a permit until the commission has promulgated every rule required to be adopted by oil and gas bills enacted in 2019 and the rules have become effective; except that the director may issue a permit if the director determines that the permit does not require additional analysis to ensure the protection of public health, safety, and welfare or the environment or require additional local government or other state agency consultation.

Pursuant to commission rule, an operator may submit a statewide blanket financial assurance of $60,000 for fewer than 100 wells or $100,000 for 100 or more wells. Section 11 directs the commission to adopt rules that require financial assurance sufficient to provide adequate coverage for all applicable requirements of the Act. Current law allows the commission to set numerous fees used to administer the Act and sets a $200 or $100 cap on the fees. Section 11 eliminates the caps and requires the commission to set a permit application fee in an amount sufficient to recover the commission's reasonably foreseeable direct and indirect costs in conducting the analysis necessary to assure that permitted operations will be conducted in compliance with all applicable requirements of the Act.

Current law gives the commission the authority to regulate oil and gas operations so as to prevent and mitigate "significant" adverse environmental impacts to the extent necessary to protect public health, safety, and welfare, taking into consideration cost-effectiveness and technical feasibility. Section 11 requires the commission to protect and minimize adverse impacts to public health, safety, and welfare, the environment, and wildlife resources and protect against adverse environmental impacts on any air, water, soil, or biological resource resulting from oil and gas operations. Section 11 also requires the commission to adopt rules that require alternate location analyses for oil and gas facilities that are proposed to be located near populated areas and that evaluate and address the cumulative impacts of oil and gas development. Finally, section 11 directs the commission to promulgate rules to:

- ★ Ensure proper wellhead integrity of all oil and gas production wells, including the use of nondestructive testing of well joints and requiring certification of oil and gas field welders;
- ★ Allow public disclosure of flowline information and to evaluate and determine when a deactivated flowline must be inspected before being reactivated; and
- ★ Evaluate and determine when inactive and shut-in wells must be inspected before being put into production or used for injection.

Current law authorizes "forced" or "statutory" pooling, a process by which "any interested person", typically an operator who has at least one lease or royalty interest, may apply to the commission for an order to pool oil and gas resources located within a particularly identified drilling unit. After giving notice to interested parties and holding a hearing, the commission can adopt a pooling order to require an owner of oil and gas resources within the drilling unit who has not consented to the application (nonconsenting owner) to allow the operator to produce the oil and gas within the drilling unit notwithstanding the owner's lack of consent. **Section 12** requires that the owners of more than 50% of the mineral interests to be pooled must have joined in the application for a pooling order and that the application include either: Proof that the applicant has already filed an application with the affected local government to approve the siting of the proposed oil and gas facilities and of the local government's disposition of the application; or proof that the affected local government does not regulate the siting of oil and gas facilities. Section 12 also specifies that the operator cannot use the surface owned by a nonconsenting owner without permission from the nonconsenting owner.

Current law also sets the royalty that a nonconsenting owner is entitled to receive at 12.5% of the full royalty rate until the consenting owners have been fully reimbursed (out of the remaining 87.5% of the nonconsenting owner's royalty) for their costs. Section 12 raises a nonconsenting owner's royalty rate during this pay-back period from 12.5% to 15% and makes a corresponding reduction of the portion of the nonconsenting owner's royalty from which the consenting owners' costs are paid.

Current law requires the commission to ensure that the 2-year average of the unobligated portion of the oil and gas conservation and environmental response fund does not exceed $6 million and that there is an adequate balance in the environmental response account in the fund to address environmental response needs. **Section 13** directs the commission to ensure that the unobligated portion of the fund does not exceed 50% of total appropriations from the fund for the upcoming fiscal year and that there is an adequate balance in the account to support the operations of the commission and to address environmental response needs.

Section 15 amends preemption law by specifying that both state agencies and local governments have authority to regulate oil and gas operations and establishes that, where there is a conflict in the exercise of that authority, the more protective standard as to health, safety, and welfare, the environment, and wildlife resources controls.
(Note: This summary applies to this bill as introduced.)

Status: 3/1/2019 Introduced In Senate - Assigned to Transportation & Energy
3/5/2019 Senate Committee on Transportation & Energy Refer Amended to Finance
3/7/2019 Senate Committee on Finance Refer Amended to Appropriations
3/8/2019 Senate Committee on Appropriations Refer Amended to Senate Committee of the Whole

Date Introduced: 2019-03-01

Amendments: Amendments

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DATA BRIEF NO. 30 | FEBRAURY 2019

Colorado Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines

Nationally, consumer worry about healthcare affordability is well documented but now – for the first time—a new survey reveals how affordability concerns and ideas for action play out in Colorado.

A survey of more than 970 Colorado adults conducted from December 20, 2018 to January 2, 2019, found that:

- More than half experienced healthcare affordability burdens in the past year;
- Even more are worried about affording healthcare in the future; and
- Across party lines, they express strong support for policymakers to address these problems.

A Range of Healthcare Affordability Burdens

Like many Americans, Colorado residents currently experience hardship due to high healthcare costs. All told, **58%** of Colorado adults experienced one or more of the following healthcare affordability burdens in the prior 12 months.

1.) Being Uninsured Due to High Premium Costs

- **62%** of uninsured adults cited "too expensive" as the major reason for not having coverage, far exceeding reasons like "don't need it," "don't know how to get it" and other potential barriers.

2.) Delaying or Foregoing Healthcare Due to Cost

Half (**50%**) of Colorado adults who needed healthcare during the year encountered one or more cost related barriers to getting that care. In descending order of frequency, they report the following healthcare short-cuts to deal with cost:

- **39%**—Delayed going to the doctor or having a procedure done
- **34%**—Avoided going altogether to the doctor or having a procedure done
- **33%**—Skipped a recommended medical test or treatment
- **22%**—Did not fill a prescription
- **20%**—Cut pills in half or skipped doses of medicine
- **18%**—Had problems getting mental healthcare

Moreover, cost was by far the most frequently cited reason (27%) for not getting needed medical care, exceeding a host of other possible barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier were doctor bills, dental bills and prescription drugs, likely reflecting the frequency with which Colorado adults seek these services—or, in the case of dental, perhaps lower rates of coverage for these services.

Struggling to Pay Medical Bills

More than one-third (39%) of Colorado adults experienced one or more of these struggles to pay their medical bills:

- **20%**—used up all or most of their savings
- **17%**—unable to pay for basic necessities like food, heat, or housing
- **15%**—contacted by a collection agency
- **11%**—borrowed money or got a loan or another mortgage on their home
- **10%**—racked up large amounts of credit card debt
- **10%**—placed on a long-term payment plan

High Levels of Worry About Affording Healthcare in the Future

Even adults not currently facing a healthcare affordability burden report being worried about affording healthcare in the future.

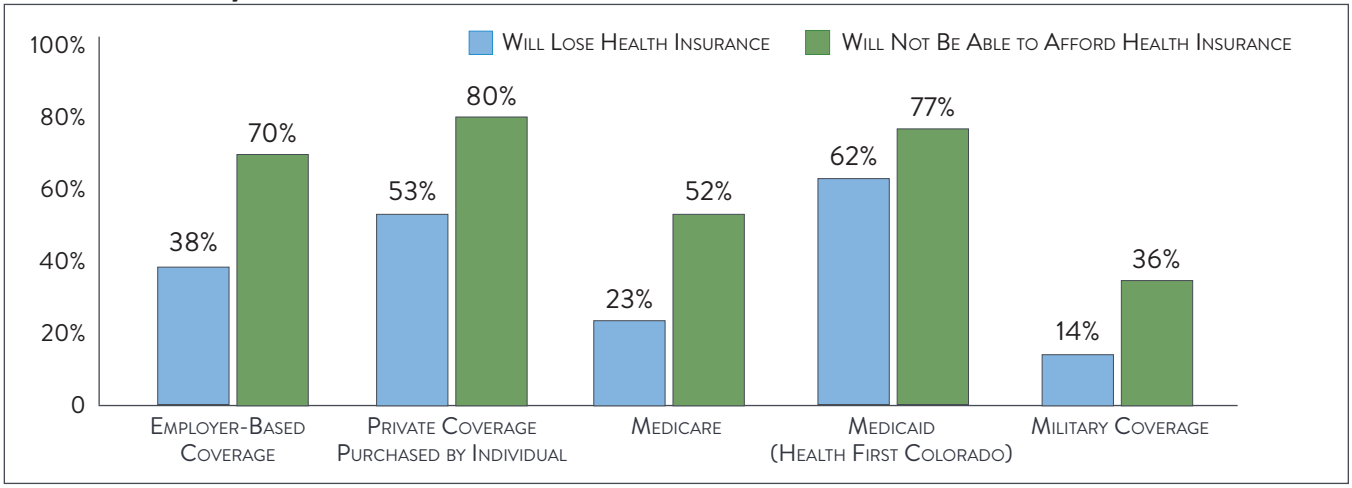
Overall, four out of five (**82%**) Colorado adults reported being "worried" or "very worried" about affording one or more aspects of healthcare, such as:

- **68%**—Won't be able to afford nursing home and home care services
- **68%**—Won't be able to afford medical costs when elderly
- **66%**—Cost of a serious illness or accident
- **53%**—Prescription drug costs

In addition, respondents were "worried" or "very worried" about not being able to afford health insurance in the future (**68%**). The greatest concern was among those that buy private health coverage and those that have Medicaid (Health First Colorado)—more than three quarters of those adults expressed worry (see Figure 1). In light of low cost of coverage for Medicaid recipients, it is possible that fears of affordability were related to fears about losing this coverage. As Figure 1 shows, more than half of Medicaid recipients were worried about losing their coverage.

Figure 1

Somewhat or Very Worried About Health Insurance



Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Regional Differences in Healthcare Affordability Burdens

The survey also revealed some regional differences in how Colorado experience healthcare affordability burdens. Responses were mapped into the regions in Table 1.

Table 1

Regional Healthcare Burden Differences in Colorado

	Percent of State Population	Median Income	Any Healthcare Affordability Burden	Any Healthcare Affordability Worry
Denver Metro	56%	$72,799	56%	83%
Rest of Colorado	44%	$59,667	62%	82%

Source: Population and Income from U.S. Census Bureau; Income is a weighted average of median income by county.
Note: Denver Metro counties include: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park.

Individuals outside the Denver Metro Region reported the greatest rate of healthcare affordability burdens-**62%** of adults had one or more of the three types of burdens described above. In contrast, the Denver metro region showed fewer affordability burdens, although still high, affecting more than half (**56%**) of adults (see Table 1)

Perhaps reflecting these high rates of healthcare affordability burdens, residents of Colorado were fairly similar with respect to healthcare worry across regions:

- Worry about affording medical costs when elderly: **70%** for the Denver metro region, compared to **67%** for the rest of the state.
- Worry about affording the costs of serious illness or accident: **67%** for the Denver metro region, compared to **65%** for the rest of the state.

Perhaps most important, overall levels of worry about healthcare affordability exceeded 80% in both regions (Table 1).

Additional regional detail is available at healthcarevaluehub.org/Colorado-2019-healthcare-survey/

Dissatisfaction with the Health System and Support for Change

In light of these healthcare affordability concerns, it is not surprising that Colorado residents were extremely dissatisfied with the health system. Statewide:

- Just **27%** agreed or strongly agreed with the statement "We have a great healthcare system in the U.S.,"
- While **79%** agreed or strongly agreed "The system needs to change."

Of more than 20 options, the options cited most frequently as being a "major reason" for high healthcare costs were:

- **74%**—Drug companies charging too much money
- **71%**—Hospitals charging too much money
- **70%**—Insurance companies charging too much money
- **56%**—Some well-known or large hospitals or doctor groups using their influence to get higher payments from insurance companies

When it comes to tackling costs, respondents endorsed a number of strategies:

- **93%**—Make it easy to switch insurers if a health plan drops your doctor
- **93%**—Show what a fair price would be for specific procedures
- **93%**—Require insurers to provide upfront cost estimates to consumers
- **93%**—Require hospitals and doctors to provide up front patient cost estimates

What is remarkable about these findings is high support for change regardless of the respondent's political affiliation (see Table 2).

Table 2

Percent Who Agreed/Strongly Agreed, by Political Affiliation

Selected Survey Questions	Total	Generally speaking, do you think of yourself as...		
		Republican	Democrat	Neither
Do you agree we have a great healthcare system in the U.S.?	27%	39%	25%	19%
Do you agree the U.S. healthcare system needs to change?	79%	74%	84%	80%
The government should authorize the Attorney General to take legal action to prevent price gouging or unfair prescription drug price hikes	91%	89%	94%	90%
The government should require drug companies to provide advanced notice of price increases and information to justify those increases	90%	85%	96%	89%
The government should show what a fair price would be for specific procedures	93%	93%	94%	93%
Major reason for rising healthcare costs: Drug companies charging too much money	74%	70%	74%	78%
Major reason for rising healthcare costs: Hospitals charging too much money	71%	70%	73%	70%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

While Colorado residents are united in calling for a role for government in addressing high healthcare costs, they also see a role for themselves:

- **82%** would switch from a brand to a generic if given the option
- **68%** report that taking better care of their personal health is one of the top three actions that would be most effective in addressing affordability
- **46%** have tried to find out the cost of a drug beforehand

The high burden of healthcare affordability, along with high levels of support for change, suggest that elected leaders and other stakeholders need to make this consumer burden a top priority. Annual surveys can help assess whether or not progress is being made.

Methodology

Altarum's Consumer Healthcare Experience State Survey (CHESS) is designed to elicit respondents' unbiased views on a wide range of health system issues, including confidence using the health system, financial burden, and views on fixes that might be needed.

The survey used a web panel from SSI Research Now containing a demographically balanced sample of approximately 1,000 respondents who live in Colorado. The survey was conducted only in English and restricted to adults ages 18 and older. Respondents who finished the survey in less than half the median time were excluded from the final sample, leaving 971 cases for analysis with sample balancing occurring in age, gender and income to be demographically representative of Colorado. After those exclusions, the demographic composition of respondents is as follows.

Demographic Composition of Survey Respondents

Demographic Characteristic	Frequency	Percentage
Household Income		
Under $30K	116	12%
$30K - $40K	95	10%
$40K - $50K	92	9%
$50K - $60K	94	10%
$60K - $75K	116	12%
$75K - $100K	154	16%
$100K - $150K	170	18%
$150K+	134	14%
Party Affiliation		
Republican	299	31%
Democrat	323	33%
Neither	349	36%
Age		
18-24	15	<1%
25-34	135	14%
35-44	140	15%
45-54	101	10%
55-64	245	25%
65+	329	34%

Demographic Characteristic	Frequency	Percentage
Gender		
Male	464	48%
Female	507	52%
Insurance Status		
Health insurance through employer or family member's employer	425	44%
Health insurance I buy on my own	88	9%
Medicare	312	32%
Medicaid (Health First Colorado)	81	8%
TRICARE/Military Health System	28	3%
Department of Veterans Affairs (VA) Health Care	8	1%
No coverage of any type	21	2%
I don't know	8	1%
Health Status		
Excellent	174	18%
Very Good	402	41%
Good	276	28%
Fairl	104	11%
Poor	15	2%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

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With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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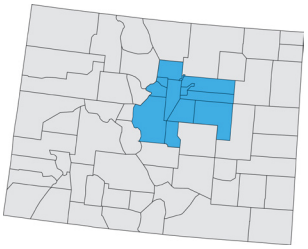
DATA BRIEF NO. 31 | FEBRUARY 2019



Denver Metro Region of Colorado: 56% of Adults Experienced Healthcare Affordability Burdens in the Past Year

According to a survey of Colorado adults conducted from Dec. 20, 2018 to Jan. 2, 2019, residents of the Denver Metro Region experienced healthcare affordability burdens at rates slightly lower than the rest of the state. All told, more than half (56%) of Denver Metro Region adults experienced one or more of the following healthcare affordability burdens in the prior 12 months.

1.) Being Uninsured Due to High Premium Costs

- 54% of uninsured Denver area adults cited "too expensive" as the major reason for not having coverage, far exceeding reasons like "don't need it" and "don't know how to get it."

2) Delaying or Foregoing Healthcare Due to Cost

Nearly one-half (48%) of Denver Metro Region adults who needed healthcare during the year encountered one or more cost related barriers to getting that care. In descending order of frequency, they reported:

- 37%—Delayed going to the doctor or having a procedure done
- 33%—Avoided going altogether to the doctor or having a procedure done
- 31%—Skipped a recommended medical test or treatment
- 22%—Did not fill a prescription
- 20%—Cut pills in half or skipped doses of medicine
- 19%—Had problems getting mental healthcare

Cost was far and away the most frequently cited reason for not getting needed medical care, exceeding other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier were doctor bills, prescription drugs and dental care, likely reflecting the frequency with which the Denver Metro Region adults seek these services—or, in the case of dental, lower rates of coverage for these services.

3) Many Who Received Care Struggle to Pay the Resulting Medical Bills

More than one-third (39%) of Denver Metro Region adults experienced one or more of these struggles to pay their medical bills:

- 22%—Used up all or most of their savings
- 19%—Were unable to pay for basic necessities like food, heat, or housing
- 16%—Contacted by a collection agency
- 11%—Borrowed money or got a loan or another mortgage on their home
- 9%—Racked up large amounts of credit card debt
- 9%—Placed on a long-term payment plan

High Levels of Worry About Affording Healthcare in the Future

Residents of the Denver Metro Region also exhibited high levels of worry about affording healthcare in the future. In descending order, respondents were "worried" or "very worried" about: health insurance becoming too expensive (72%); affording nursing home and home care services (71%); costs when elderly (70%); cost of a serious illness or accident (67%); prescription drug costs (55%); losing health insurance (41%).

Dissatisfaction with the Health System and Support for Change

Denver Metro Region residents were extremely dissatisfied with the health system. Just 28% agreed or strongly agreed with the statement "We have a great health care system in the U.S.," while 78% agreed or strongly agreed with "the system needs to change."

Respondents do see a role for themselves in solving problems. They reported actions they have already taken, like researching the cost of drug beforehand (45%), as well as actions they should be taking—68% believe that taking better care of their personal health is one of the top things they can do personally to address affordability.

But in far greater numbers they saw a role for their elected representatives. Strategies typically received support across party lines and include (Total/Republican/Democrat/Neither):

- Authorize the Attorney General to take legal action to prevent price gouging or unfair prescription drug price hikes (94%/93%/96%/92%)
- Require insurers to provide upfront cost estimates to consumers—(93%/87%/96%/95%)
- Show what a fair price would be for specific procedures—(95%/92%/96%/95%)
- Make it easy to switch insurers if a health plan drops your doctor—(92%/90%/90%/96%)

The high burden of healthcare affordability, along with high levels of support for change, suggest that elected leaders and other stakeholders need to make addressing the cost of healthcare a top priority. Annual surveys of residents' affordability burdens can help assess whether or not progress is being made.

Note: For survey methodology and state-wide data, see https://www.healthcarevaluehub.org/Colorado-2019-Healthcare-Survey

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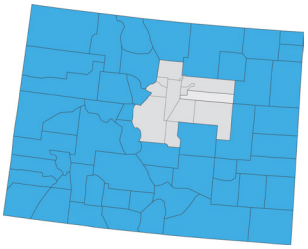
DATA BRIEF NO. 32 | FEBRUARY 2019



Outside the Denver Metro Region: 62% of Adults Experienced Healthcare Affordability Burdens in the Past Year

According to a survey conducted from Dec. 20, 2018 to Jan. 2, 2019, Colorado residents outside the Denver Metro Region experienced healthcare affordability burdens at somewhat higher rates compared to the Denver region. All told, in the prior 12 months, nearly two-thirds (**62%**) of adults outside the Denver region experienced one or more of the following healthcare affordability burdens.

1.) Being Uninsured Due to High Premium Costs

- **76%** of uninsured adults outside the Denver region cited "too expensive" as the major reason for not having coverage, far exceeding reasons like "don't need it" and "don't know how to get it."

2) Delaying or Foregoing Healthcare Due to Cost

Well over half (**54%**) of Colorado adults outside the Denver region who needed healthcare during the year encountered one or more cost-related barriers getting care. In descending order of frequency, they reported:

- **44%**—Delayed going to the doctor or having a procedure done
- **38%**—Avoided going altogether to the doctor or having a procedure done
- **37%**—Skipped a recommended medical test or treatment
- **21%**—Did not fill a prescription
- **19%**—Cut pills in half or skipped doses of medicine
- **16%**—Had problems getting mental healthcare

Cost was far and away the most frequently cited reason for not getting needed medical care, exceeding other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier in decending order of frequency were dental care, doctor bills and prescription drugs, likely reflecting the frequency with which adults seek these services—or, in the case of dental, lower rates of coverage for these services.

3) Many Who Received Care Struggle to Pay the Resulting Medical Bills

Two out of five (**40%**) of Colorado adults residing outside the Denver region experienced one or more of these struggles to pay their medical bills:

- **17%**—Used up all or most of their savings
- **15%**—Were unable to pay for basic necessities like food, heat, or housing
- **14%**—Were contacted by a collection agency
- **11%**—Borrowed money or got a loan or another mortgage on their home
- **9%**—Racked up large amounts of credit card debt
- **8%**—Placed on a long-term payment plan

High Levels of Worry About Affording Healthcare in the Future

Coloradans outside the Denver region also exhibited high levels of worry about affording healthcare in the future. In descending order, respondents were "worried" or "very worried" about: costs when elderly (67%); cost of a serious illness or accident (65%); health insurance becoming too expensive (63%); affording nursing home and home care services (63%); prescription drug costs (49%); losing health insurance (38%).

Dissatisfaction with the Health System and Support for Change

Colorado adults outside the Denver region were extremely dissatisfied with the health system. Just 24% agreed or strongly agreed with the statement "We have a great health care system in the U.S.," while 82% agreed or strongly agreed with "the system needs to change."

Respondents do see a role for themselves in solving problems. They reported actions they have already taken, like researching the cost of drug beforehand (48%), as well as actions they can take in the future—69% believe that taking better care of their personal health is one of the top things they can do personally to address affordability.

But in far greater numbers they saw a role for their elected representatives. Strategies typically received support across party lines and include (Total/Republican/Democrat/Neither):

- Make it easy to switch insurers if a health plan drops your doctor—(94%/89%/99%/95%)
- Require insurers to provide upfront cost estimates to consumers—(94%/90%/97%/95%)
- Require hospitals to provide upfront cost estimates to consumers—(93%/92%/93%/95%)
- Prohibit drug companies from charging more in the U.S. than abroad—(92%/86%/98%/91%)

The high burden of healthcare affordability, along with high levels of support for change, suggest that elected leaders and other stakeholders need to make addressing the cost of healthcare a top priority. Annual surveys of residents' affordability burdens can help assess whether or not progress is being made.

Note: For survey methodology and state-wide data, see https://www.healthcarevaluehub.org/Colorado-2019-Healthcare-Survey

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DATA BRIEF NO. 33 | FEBRUARY 2019

Many Privately-Insured Colorado Residents Receive Unexpected Medical Bills; Nearly One-Half Unhappy with Resolution, May Not Understand Options for Assistance

Unexpected medical bills are surprisingly common. They can take many forms, from higher than expected charges, to bills from unexpected doctors, to bills from out-of-network providers when patients thought they were in-network. Federal and state legislators, including those in Colorado, are taking a close look at these issues, particularly cases where patients received an unexpected bill from an out-of-network provider through no fault of their own.

A 2018-2019 survey of Colorado adults examines how prevalent these experiences are in the state. Though respondents report receiving unexpected bills regardless of insurance status, this analysis focuses on the respondents with private insurance (more than 500 responses).[1]

One-third of privately-insured Colorado adults received a medical bill they were not expecting. Surprise medical bills are very common. Altogether, **34%** of privately-insured Colorado adults reported receiving a medical bill that included an unexpected expense in the prior 12 months. These privately-insured adults reported these specific issues:

- **23%**—The amount charged was higher than expected
- **14%**—A bill from a doctor they didn't expect

Smaller numbers reported being charged out-of-network rates when they thought the doctor was in-network (**7%**); being charged for services they did not receive (**3%**) or reported something else unexpected (**5%**). The prevalence of unexpected bills aligns well with similar surveys of privately-insured adults from other states.[2]

Privately-insured adults in Colorado tried a number of strategies to address the surprise bill but were often not satisfied with the resolution. Nearly three-quarters (**72%**) of privately-insured Colorado residents who received a surprise bill made an effort to resolve the bill before paying it. As a first step, **40%** contacted their insurance plan and **31%** contacted their doctor, hospital or lab to resolve their unexpected medical bill (see Table 1).

Table 1: First Step After Receipt of Unexpected Medical Bill

Contacted the health plan or consulted insurance policy/provider directory	40%
Contacted doctor, hospital or lab	31%
Paid the bill without disputing it	16%
Asked a friend or family member for help	1%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, privately insured who received an unexpected medical bill, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Just **18%** of privately insured Colorado adults who experienced a surprise bill took more than one step to resolve the unexpected bill. Almost no respondents reported any of these courses of action:

- Contacting an insurance broker
- Filing an insurance appeal
- Contacting a consumer assistance program
- Contacting a state government agency
- Contacting state legislators or member of Congress
- Contacting a lawyer
- Filing a formal complaint

Among privately-insured Colorado adults with an unexpected medical bill in the past 12 months, most (65%) paid the bill in full or through a payment plan. A minority were able to negotiate a lower bill or have their bill dismissed (**21%**) while **4%** of privately insured respondents indicated their unexpected medical bill was sent to collections and remains unpaid (see Table 2).

Table 2: Payment Status of Unexpected Medical Bill

Paid original bill in full	43%
Paid original bill through a payment plan	22%
Negotiated a lower bill	11%
Billing issue was dismissed or written off	10%
Bill was sent to collections and remains unpaid[2]	4%
Bill had not been resolved	11%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, privately insured who received an unexpected medical bill, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Nearly one-half of unexpected medical bills were not resolved satisfactorily; many remain unresolved.

Among privately-insured Colorado adults who had an unexpected medical bill, just over one-quarter indicated that the issue was resolved to their satisfaction. Almost one-half indicated that the issue was not resolved to their satisfaction. For another 21%, they don't consider the issue resolved (see Table 3).

Table 3: Satisfaction with Resolution of Unexpected Medical Bill

Issue was resolved but not to their satisfaction	47%
Issue was resolved to their satisfaction	26%
Issue is still not resolved	21%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, privately insured who received an unexpected medical bill, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey. Components do not add to 100% due to some respondents being unsure of bill resolution.

Both satisfied and dissatisfied consumers reported attempting to contact the health plan or consulted their insurance policy or provider directory in equal amounts when they received their unexpected bill. Additionally, both satisfied and dissatisfied consumers were likely to have tried additional strategies such as contacting a customer assistance program. However, dissatisfied consumers reported less attempts to contact the doctor, hospital or lab after receipt of an unexpected bill compared to satisfied consumers and more often paid the bill without disputing it (see Table 4).

Table 4: Resolution Strategies Differ Between Dissatisfied and Satisfied Patients

Strategies	Dissatisfied with Bill Resolution		Satisfied with Bill Resolution
Paying the bill without disputing it	18%	vs.	7%
Contacted the health plan or consulted insurance policy/provider directory	45%	vs.	44%
Contacted the doctor, hospital or lab	31%	vs.	44%
Contacted a customer assistance program	2%	vs.	3%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, privately insured who received an unexpected medical bill that was resolved, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey.

Perhaps not surprisingly, consumers satisfied with how their medical bill was resolved were more likely to have either negotiated a lower payment or had their bill written off or dismissed (see Table 5).

Table 5: Resolution of Unexpected Medical Bills, by Type of Resolution

	Dissatisfied with Bill Resolution	Satisfied with Bill Resolution
Paid original bill in full/through a payment plan	86%	46%
Bill unpaid and sent to collections	3%	0%
Billing issue dismissed or written off	0%	25%
Negotiated a lower bill	10%	21%

Source: 2018 Poll of Utah Adults, Ages 18+, privately insured who received an unexpected medical bill that was resolved, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey. Components do not add to 100% due to some respondents being unsure of bill resolution.

Discussion

Privately-insured Colorado adults receive unexpected medical bills in high numbers. The nature of these bills takes many forms, from higher than expected charges, to bills from doctors they didn't expect, to surprise out-of-network bills. Distressingly, nearly one-half of these unexpected bills are not resolved to the satisfaction of the recipient. These Colorado findings are consistent with other national survey data showing unacceptably high rates of unexpected medical bills.

Data showing that survey respondents made only modest efforts to resolve their bill—and that many remain unsatisfied—are consistent with other survey data showing that consumers have a poor understanding of how to navigate the healthcare system. Consumers may not know they have

the right to appeal a coverage decision, how to seek help from state regulators or how to navigate hospital charity care policies.[3]

As states address the issue of surprise medical bills related to out-of-network care, they are emphasizing the need to get the consumer out of the middle—strategies such as better consumer notices and prohibiting balance billing by providers in certain circumstances. When balance billing is prohibited, these consumer protections must be accompanied by a mechanism to resolve the out-of-network provider's bill.

Other efforts states are undertaking include simplifying health plan benefit designs[4] and improving the accuracy of provider directories and adequacy of provider networks. In light of poll results showing that few bill recipients take more than one step to resolve their bill, Colorado policy makers may also want to consider creating a dedicated state ombudsman's office to help consumers with their billing problems, such as available in Connecticut and Vermont.[5]

Notes

1. These privately-insured respondents include those covered by plans regulated at the state level ("fully insured" plans), as well as plans regulated by the U.S. Department of Labor (ERISA or "self-insured" plans). The later are typically the plans offered by larger employers.
2. A Consumer Reports survey finds nearly one third of privately insured Americans hit with surprise medical bills, Consumer Reports (August 2018). https://www.consumerreports.org/medical-billing/sick-of-confusing-medical-bills/ In addition, a Kaiser Family Foundation survey finds that among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about one-third of the time. A study by Yale University found 22% of visits to emergency departments resulted in surprise medical bills.
3. A 2014 Kaiser Family Foundation survey found one-third of respondents did not know that if a health plan refuses to pay for a medically recommended service, an insured person has the right to appeal the plan's decision. *https://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/.* A separate 2015 survey found three-quarters of privately insured adults are unsure if they have the further right to appeal to the state/an independent medical expert if their health plan refuses coverage for medical services they think they need. Few (just 13%) could identify the state agency/department tasked with handling health insurance complaints. *https://consumersunion.org/research/surprise-bills-survey/*
4. For examples, see Corlette, et al., *Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs*, Urban Institute (July 2016).
5. Hunt, Amanda, *The Office of the Healthcare Advocate: Giving Consumers a Seat at the Table*, Research Brief No. 25, Healthcare Value Hub (May 2018).

Methodology

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$40K - $50K	92	9%
$50K - $60K	94	10%
$60K - $75K	116	12%
$75K - $100K	154	16%
$100K - $150K	170	18%
$150K+	134	14%
Party Affiliation		
Republican	299	31%
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55-64	245	25%
65+	329	34%

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Female	507	52%
Insurance Status		
Health insurance through employer or family member's employer	425	44%
Health insurance I buy on my own	88	9%
Medicare	312	32%
Medicaid (Health First Colorado)	81	8%
TRICARE/Military Health System	28	3%
Department of Veterans Affairs (VA) Health Care	8	1%
No coverage of any type	21	2%
I don't know	8	1%
Health Status		
Excellent	174	18%
Very Good	402	41%
Good	276	28%
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Poor	15	2%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

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DATA BRIEF NO. 34 | FEBRUARY 2019

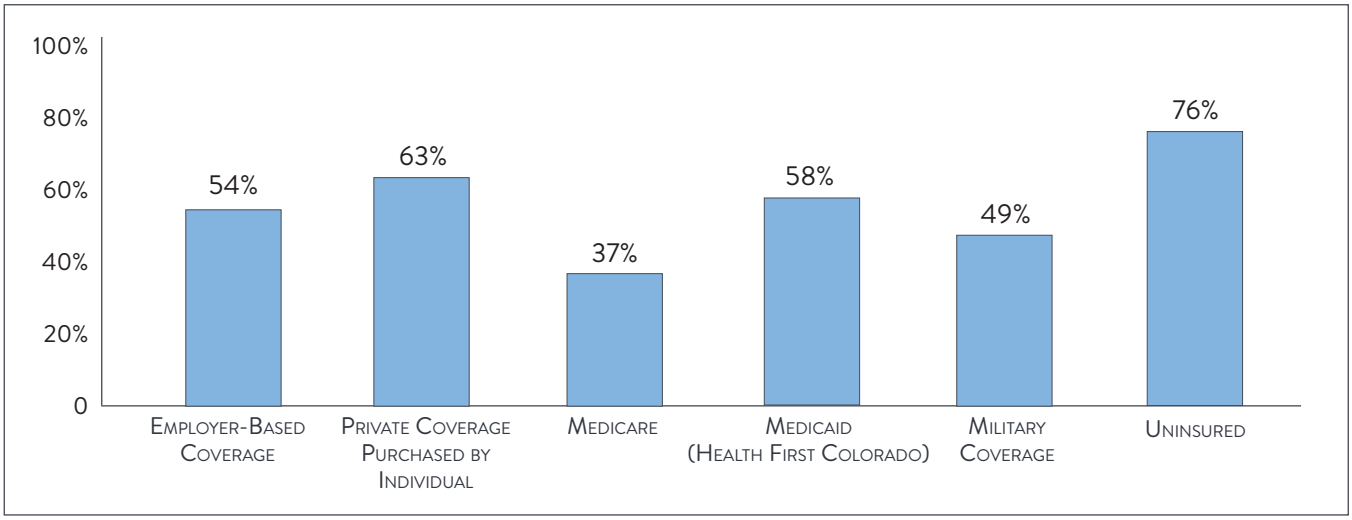
Colorado Residents Worried about High Drug Costs–Support a Range of Government Solutions

According to a survey of more than 970 Colorado adults conducted from Dec. 20, 2018 to Jan. 2, 2019, Coloradans are extremely concerned about prescription drug costs and express a strong desire to enact solutions.

More than half (**53%**) of all survey respondents reported being either "worried" or "very worried" about affording the cost of prescription drugs. The uninsured, those that purchase private coverage individually, and those on Medicaid are the most concerned about affording drugs (see Figure 1).

Figure 1

Somewhat or Very Worried About Affording Prescription Drugs



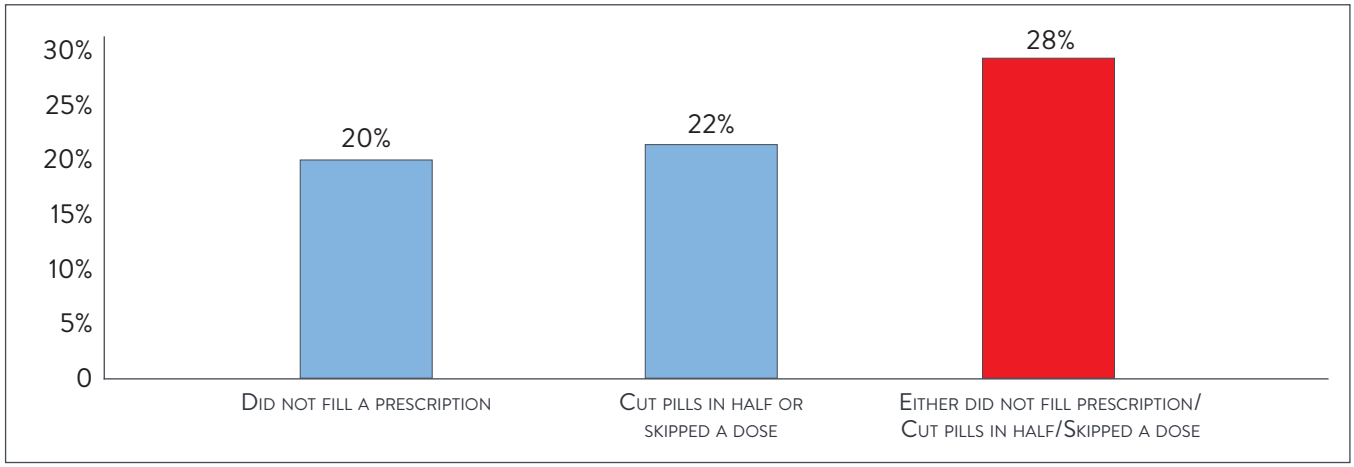
Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Concerns about affording drugs may be tied to concerns about the security of health coverage. As detailed in a companion data brief,[1] many respondents are worried about losing their health coverage or being unable to afford their insurance, with those on Medicaid and those that buy private insurance coverage on their own (not thorough an employer) having the highest rates of insurance worry.

In addition to high levels of worry, many Colorado residents are currently experiencing hardship due to drug costs. One-fifth (**20%**) of respondents report it was "Difficult" or "Extremely Difficult" to afford their prescription drugs. In addition, **28%** of survey respondents report not filling a

Figure 2

Did not Fill a Prescription, Cut Pills in Half or Skipped a Dose Due to Concerns About Cost



Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

prescription and/or cutting pills in half in the prior 12 months due to concerns about cost (see Figure 2).

In light of concerns about high healthcare costs—including prescription drug costs—it is not surprising that Colorado residents are extremely dissatisfied with the health system:

- Only **27%** agree or strongly agree with the statement "We have a great health care system in the U.S."
- While **79%** agree or strongly agree "the system needs to change."

When given more than 20 options, the option cited most frequently as being a "major reason" for high healthcare costs were drug companies charging too much money:

- **74%**—Drug companies charging too much money
- **71%**—Hospitals charging too much money
- **70%**—Insurance companies charging too much money
- **56%**—Some well-known or large hospitals or doctor groups using their influence to get higher payments from insurance companies

When it comes to tackling high drug costs specifically, respondents endorsed a number of strategies:

- **91%**—Authorize the Attorney General to take legal action to prevent price gouging or unfair prescription drug price hikes
- **90%**—Require drug companies to provide advanced notice of price increases and information to justify those increases
- **89%**—Set standard prices for drugs to make them affordable

What is remarkable about the findings is high support for change regardless of the respondent's political affiliation (see Table 1).

Table 1

Percent Who Agree/Strongly Agree, by Political Affiliation

Selected Survey Questions	Total	Generally speaking, do you think of yourself as...		
		Republican	Democrat	Neither
Major reason for rising healthcare costs: Drug companies charging too much money	74%	70%	74%	78%
The government should authorize the Attorney General to take legal action to prevent price gouging or unfair prescription drug price hikes	91%	89%	94%	90%
The government should require drug companies to provide advanced notice of price increases and information to justify those increases	90%	88%	92%	89%
The government should set standard prices for drugs to make them affordable	89%	83%	94%	89%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

While government action was strongly viewed as more effective to address high drug costs, respondents also saw a role for themselves in solving problems. They reported actions they have already taken, like researching the cost of drug beforehand (**46%**), as well as future actions—**82%** believe that switching to a generic if given the option is one of the top things they can do personally to address affordability.

Note

1. See: Healthcare Value Hub, *Colorado Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines*, Data Brief No. 30 (February 2019). www.healthcarevaluehub.org/Colorado-2019-Healthcare-Survey/

Methodology

Altarum's Consumer Healthcare Experience State Survey (CHESS) is designed to elicit respondents' unbiased views on a wide range of health system issues, including confidence using the health system, financial burden, and views on fixes that might be needed.

The survey used a web panel from SSI Research Now containing a demographically balanced sample of approximately 1,000 respondents who live in Colorado. The survey was conducted only in English and restricted to adults ages 18 and older. Respondents who finished the survey in less than half the median time were excluded from the final sample, leaving 971 cases for analysis with sample balancing occurring in age, gender and income to be demographically representative of Colorado. After those exclusions, the demographic composition of respondents is as follows.

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Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

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DATA BRIEF NO. 35 | FEBRAURY 2019

Colorado Residents Worried about High Hospital Costs

While hospitals are important providers of healthcare and vital members of our communities, a poll of Colorado adults, conducted from Dec. 20, 2018 to Jan. 2, 2019, finds there is great concern about hospital costs as well as a desire to enact solutions.

For context, nationally only about **7%** of the adult population stays overnight in the hospital in any given year.[1] A far greater number visit the emergency department (ED), often without being admitted for an overnight stay. In 2017, **20%** of Colorado adults visited an ED, and some of those patients end up being admitted.[2]

Hardship and Worry about Hospital Costs

Many Colorado residents are currently experiencing hardship due to hospital costs. Ten percent of respondents had trouble affording their hospitalization in the past 12 months.

Even more are worried about affording healthcare in the future. Two-thirds (**66%**) of all survey respondents reported being either "worried" or "very worried" about affording the cost of hospital care from a serious illness or accident.

Skills Navigating Hospital Care

Colorado adults report being fairly confident in terms of knowing when to seek emergency care but are less confident in their ability to find quality information or fix a problem with the hospital. The share reporting they are very or extremely confident:

- **65%**—knowing when to seek care in the hospital emergency department vs their primary care physician
- **50%**—can find quality ratings for hospitals.
- **41%**—know what steps to take to address a problem they were having with their hospital stay or bill.

Furthermore, respondents expressed a willingness to seek out hospital price and quality information:

- **22%**—tried to find out the cost of a hospital stay ahead of time.
- **42%**—tried to find quality information about hospitals, although not always successfully (see Table 1).

Table 1

Colorado Residents Who Tried to Find Hospital Quality Information in Prior 12 Months

Sought quality information and found the information they were seeking	28%
Sought quality information but could not find the information they were seeking	14%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

But other data from the survey suggests that these efforts aren't always successful in keeping consumers safe from surprise medical bills. When asked about surprise bills, about half (**53%**) of those reporting unexpected medical bills said that at least one such bill came from a hospital.[3]

Support for Hospital-Related "Fixes" Across Party Lines

Hospitals, along with drug manufacturers and insurance companies, were viewed as contributing to high costs. When given more than 20 options, the options cited most frequently as being a "major reason" for high healthcare costs were:

- **74%**—Drug companies charging too much money
- **71%**—Hospitals charging too much money
- **70%**—Insurance companies charging too much money

Across party lines, respondents strongly endorsed a number of hospital-related strategies:

- **93%**—Require hospitals and doctors to provide up front patient cost estimates[4]
- **89%**—Set standard payment to hospitals for specific procedures
- **84%**—Set up an independent entity to rate doctor and hospital quality, such as patient outcomes and bedside manner
- **69%**—Pay doctors and hospitals a fixed monthly fee per patient, instead of payment for each service

Table 2

Percent Who Agreed/Strongly Agreed, by Political Affiliation

Selected Survey Questions	Total	Generally speaking, do you think of yourself as...		
		Republican	Democrat	Neither
Major reason for rising healthcare costs: Hospitals charging too much money	71%	70%	73%	70%
Require hospitals and doctors to provide up-front patient cost estimates	93%	92%	93%	92%
Set standard payment to hospitals for specific procedures	89%	84%	96%	86%
Set up independent entity to rate doctor and hospital quality, such as patient outcomes and bedside manner	84%	80%	89%	82%
Pay doctors and hospitals a fixed monthly fee per patient, instead of payment for each service	69%	56%	73%	54%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Discussion

In Colorado (as in other states), hospital spending is significant—representing **34%** of total health spending.[5] Of concern, the Colorado Department of Health Care Policy and Financing has reported high price growth for this sector.[6] Moreover, state data shows that capital expenditures for the hospital industry in Colorado were higher than almost all other states, with state officials liken it to an "arms race."[7] At the same time, Colorado's hospitals generate some of the nation's largest profit margins while also amassing billions in reserves.[8]

The findings from this poll suggest Colorado consumers are highly motivated when it comes to searching for hospital care. However, respondents express a strong support for new price and quality transparency tools to help them better navigate hospital care.

Importantly, transparency approaches, combined with consumer shopping, are not deemed by respondents as sufficient to address their grave healthcare affordability concerns. Stronger measures are also needed. Some specific approaches were included in the survey (see Table 2, above) but policymakers should look at the full suite of evidence-based options in order to be fully responsive to Colorado adults' strong, bi-partisan call for governmental action.

Notes

1. National Health Interview Survey, *Summary Health Statistics* (2016).
2. Colorado Health Access Survey, *Use of Health Care* (September 2017).
3. Respondents could select more than one option for the source of their surprise bill.
4. Colorado has a law that went into effect in January 2018 that mandates hospitals to post the self-pay prices of common procedures but one observer notes "in searching for prices at two acute care hospitals in the state, it's difficult to make an apple-to-apple comparison." Prices will not reflect the total amount a patient may owe after receiving healthcare services- potentially excluding professional physician fees, medications, medical devices, or rehab or home health services. See: https://www.healthcarefinancenews.com/news/colorado-signs-law-mandatinghospitals-post-self-pay-prices
5. Colorado Hospital Association and the Colorado Health Institute, from *Affordability in Colorado*, page 4.
6. Osher, Christopher, "Coloradans Pay More as Hospital Building Spree Leads to Empty Beds and Profits Nearly Twice the National Average," *The Denver Post* (Oct. 4, 2018).
7. Ibid.
8. Ibid.

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DATA BRIEF NO. 36 | FEBRAURY 2019

Colorado Residents Concerned About Healthcare Quality; Unsure How to Find Answers

A new survey of more than 970 Colorado adults conducted from Dec. 20, 2018 to Jan. 2, 2019, found that:

- More than half (**66%**) of adults are worried about getting low-quality healthcare
- Only a little over one-third (**35%**) used quality information to decide on a particular doctor or hospital

What Does Healthcare Quality Mean

National survey data and qualitative research have signaled that patients often have a different view of what healthcare quality means compared to researchers or doctors.[1] Findings from the Colorado survey align well with this national data.

Out of three choices, Colorado consumers most commonly selected this definition for healthcare quality: "how doctors and office staff treat patients, such as bedside manner." However, the other two definitions tested were selected at only a modestly lower frequency (see Table 1).

Table 1

Which Definition of "Healthcare Quality" Best Reflects Your View?

How doctors and office staff treat patients, such as bedside manner	39%
Doctors and hospitals being credentialed and following evidence-based guidelines	32%
How quickly and how well the patient recovered	28%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

In light of the importance of bedside manner to Coloradans, good news from the survey is that about three-fourths (**76%**) of adults in Colorado indicated they almost always or always feel that their doctors treat them with respect.

Confidence in Finding Quality Information is Low

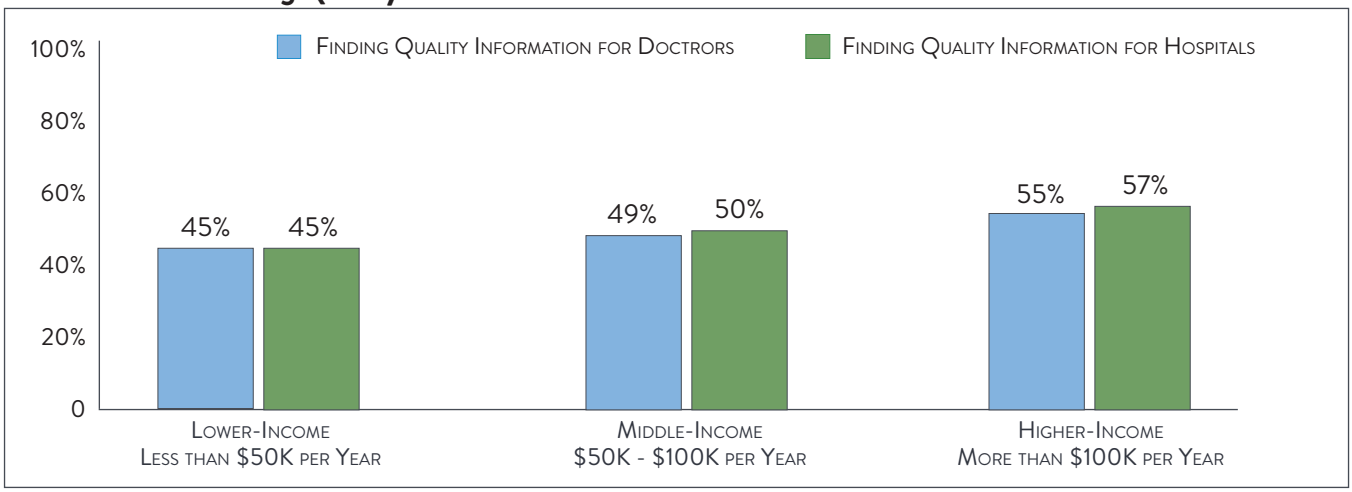
When it comes to selecting quality providers, adults in Colorado are not confident in their ability to find quality ratings for doctors or hospitals. Only about **50%** of respondents reported they were "very" or "extremely confident" they could perform these tasks.[2]

By way of comparison, respondents were far more confident they could perform health system tasks like "Follow Medical Directions from a provider" (**81%** "Very" or "Extremely Confident") or "Fill a prescription" (**78%** "Very" or "Extremely Confident").

Compared to others, lower income adults had the least confidence in finding quality information for doctors and hospitals but, more importantly, there were low degrees of confidence at all income levels (see Figure 1).

Figure 1

Confidence in Finding Quality Information



Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Does Higher Quality Come at a Higher Cost?

In light of well-documented, widespread variation in clinical quality and price,[3] it is clear that consumers need both price and quality data if they are to successfully identify providers and treatment options that are of "good value." Researchers have established that if comparison measures fail to provide quality data alongside price information, consumers may use high price as a proxy for high quality,[4] despite the fact that there is little relationship between the quality and price of a medical service.[5] This survey investigates Colorado respondents' views on the relationship between quality and price.

More than half of Colorado adults (**61%**) believe that higher quality health care usually comes at a higher cost, yet, very few believe that price reliably signals the quality of care. In other words, they believe the quality care is likely to be high price but not all high price care is quality care. Just **25%** believe that a less expensive doctor is likely providing lower-quality care.

Just over half of respondents (**55%**) indicated that if out-of-pocket costs were about equal, quality ratings would be very or extremely important. Similarly, just over half (**53%**) of survey respondents also indicated that if quality ratings were about equal, out-of-pocket costs would be very or extremely important.

These findings suggest that quality information is an important factor in health care decisions.

Healthcare System Fixes

Fifty-two percent of respondents rated the overall quality of the healthcare system as "excellent" or "good," while far fewer gave the health system a "good" or "excellent" rating for fairness (**35%**) or affordability (**20%**).

When it comes to addressing health system problems, 4 in 5 (84%) of Colorado adults supported having the government establish an independent entity to rate doctor and hospital quality, such as patient outcomes and bedside manner. Importantly, respondents also gave a large number of other solutions high marks.[6] Remarkably, these solutions received broad support across party lines.

While Colorado residents are united in strongly calling for government action setting up an independent entity to assess quality,[7] they also see a role for themselves—albeit a far more modest one. Out of 10 possible personal actions they could take to address healthcare system problems, the action of "doing more to compare cost and quality before getting services" ranked 5th behind:

- (68%)—taking better care of their personal health
- (37%)—writing to or calling my FEDERAL representative asking them to take action on high healthcare prices and lack of affordable coverage options.
- (36%)—writing to or calling my STATE representative asking them to take action on high healthcare prices and lack of affordable coverage options
- (35%)—researching treatments myself before going to the doctor

Bottom line: while respondents indicate a willingness to use healthcare quality data, they don't see personal actions as powerful as government actions in terms of fixing the healthcare marketplace.

Summary

Varying stakeholder views about what is meant by "healthcare quality" suggest that advocates and policymakers have to tread carefully when it comes to providing quality information to keep consumers safe in the healthcare marketplace. Given the still-early-stages of healthcare quality transparency tools, it is perhaps not surprising that adults in Colorado report that quality information can be difficult to access and difficult to interpret.

Across party lines, respondents issued a strong call for an independent entity to rate doctor and hospital quality, such as patient outcomes and bedside manner.

As detailed in a companion report,[8] respondents also called for strong legislative action to address the high burden of healthcare affordability. As legislators respond to this call for action, addressing quality variation and short-comings in quality transparency tools are good companion approaches to ensure that healthcare quality is not undermined as Colorado's healthcare system is transformed.

Notes

1. For example, see: The *Patient as Consumer and the Measurement of Bedside Manner* (March 2017); *First-Of-Its-Kind Survey Reveals Significant Disconnects In How Three Key Stakeholders—Patients, Physicians, Employers—Perceive The Health Care Experience* (November 2017); "U.S. Doctors are Judged More on Bedside Manner than Effectiveness of Care, Survey Finds," *BMJ* (July 2014); and *2017 Consumer Health Care Priorities Study: What Patients and Doctors Want from the Health Care System* (November 2017)

2. A dearth of tools may contribute to Coloradans' inability to find quality information. In a national survey of state and national healthcare price and quality tools, only the "Hospital" section had a Colorado-specific tool to compare hospitals. The "Physician" section only has national databases to search for providers. See: http://www.healthcaretransparency.org/

3. Cooper, Zach, et al., T*he Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, Health Care Pricing Project (May 7, 2018). http://www.healthcarepricingproject.org/papers/paper-1

4. A 2012 study involving 1,421 consumers found that significant numbers of respondents—though not a majority—viewed higher cost as a proxy for higher quality. This was true even among those with high-deductible health plans that would expose them to a higher share of costs. But when the cost and quality information was reported side by side in an easy-to-interpret format, more respondents made high-value choices. J. H. Hibbard, J. Greene, S. Sofaer et al., "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* (March 2012).

5. Hussey, P., Wertheimer, S., and Mehrotra, A. "The Association Between Health Care Quality and Cost: A Systematic Review," *Annals of Internal Medicine* (2013).

6. For other strategies receiving high levels of support, see: Healthcare Value Hub, *Colorado Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines*, Data Brief No. 30 (February 2019). http://www.healthcarevaluehub.org/Colorado-2019-healthcare-survey/

7. At the time of this report, Colorado Governor Polis has called for a new office called the Office of Saving People Money in Health Care.

8. See: Healthcare Value Hub, Colorado Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines, Data Brief No. 30 (February 2019). http://www.healthcarevaluehub.org/Colorado-2019-healthcare-survey/

Methodology

Altarum's Consumer Healthcare Experience State Survey (CHESS) is designed to elicit respondents' unbiased views on a wide range of health system issues, including confidence using the health system, financial burden, and views on fixes that might be needed.

The survey used a web panel from SSI Research Now containing a demographically balanced sample of approximately 1,000 respondents who live in Colorado. The survey was conducted only in English and restricted to adults ages 18 and older. Respondents who finished the survey in less than half the median time were excluded from the final sample, leaving 971 cases for analysis with sample balancing occurring in age, gender and income to be demographically representative of Colorado. After those exclusions, the demographic composition of respondents is as follows.

Demographic Composition of Survey Respondents

Demographic Characteristic	Frequency	Percentage
Household Income		
Under $30K	116	12%
$30K - $40K	95	10%
$40K - $50K	92	9%
$50K - $60K	94	10%
$60K - $75K	116	12%
$75K - $100K	154	16%
$100K - $150K	170	18%
$150K+	134	14%
Party Affiliation		
Republican	299	31%
Democrat	323	33%
Neither	349	36%
Age		
18-24	15	<1%
25-34	135	14%
35-44	140	15%
45-54	101	10%
55-64	245	25%
65+	329	34%

Demographic Characteristic	Frequency	Percentage
Gender		
Male	464	48%
Female	507	52%
Insurance Status		
Health insurance through employer or family member's employer	425	44%
Health insurance I buy on my own	88	9%
Medicare	312	32%
Medicaid (Health First Colorado)	81	8%
TRICARE/Military Health System	28	3%
Department of Veterans Affairs (VA) Health Care	8	1%
No coverage of any type	21	2%
I don't know	8	1%
Health Status		
Excellent	174	18%
Very Good	402	41%
Good	276	28%
Fairl	104	11%
Poor	15	2%

Source: 2018-2019 Poll of Colorado Adults, Ages 18+, Altarum Healthcare Value Hub, Altarum's Consumer Healthcare Experience State Survey

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ABOUT ALTARUM'S HEALTHCARE VALUE HUB

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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