Senate Health and Human Services Committee

Overview

The Senate Health and Human Services Committee considers matters concerning state health programs, health insurance, environmental health, and state human services programs. The committee has legislative oversight responsibility for the Department of Human Services, the Department of Health Care Policy and Financing, the Department of Public Health and Environment, and the Health Benefit Exchange.

Legislative Staff

The following legislative staff are assigned to research issues and draft bills that may appear before the House and Senate Health Committees.

- *Legislative Council Staff*
  - Vanessa Conway, House Health, Insurance, and Environment Committee, vanessa.conway@state.co.us, 303-866-4753
  - Elizabeth Haskell, Senate Health and Human Services, elizabeth.haskell@state.co.us, 303-866-6264
  - Anne Wallace, House Public Health Care and Human Services, anne.wallace@state.co.us, 303-866-4364
  - Chris Creighton, Fiscal Analyst, chris.creighton@state.co.us, 303-866-5834
  - Ryan Long, Fiscal Analyst, ryan.long@state.co.us, 303-866-2066
  - Kerry White, Senior Fiscal Analyst, kerry.white@state.co.us, 303-866-3469
  - Bill Zepernick, Senior Fiscal Analyst, bill.zepernick@state.co.us, 303-866-4777

- *Legislative Legal Services*

  - Jerry Barry, Managing Senior Attorney, jerry.barry@state.co.us, 303-866-4341
  - Christy Chase, Managing Senior Attorney, christy.chase@state.co.us, 303-866-2008
  - Brita Darling, Senior Attorney, brita.darling@state.co.us, 303-866-2241
  - Kristen Forrestal, Senior Attorney, kristen.forrestal@state.co.us, 303-866-4217
  - Jane Ritter, Senior Attorney, jane.ritter@state.co.us, 303-866-4342

- *Joint Budget Committee*

  - Megan Davisson, Principal Legislative Analyst, megan.davisson@state.co.us, 303-866-2062
  - Carolyn Kampman, Chief Legislative Analyst, carolyn.kampman@state.co.us, 303-866-4959
  - Eric Kurtz, Chief Legislative Analyst, eric.kurtz@state.co.us, 303-866-4952
  - Kevin Neimond, Principal Legislative Analyst, kevin.neimond@state.co.us, 303-866-4958
  - Robin Smart, Legislative Analyst, robin.smart@state.co.us, 303-866-4955

Meeting Times and Locations

The Senate Health and Human Services Committee meets Wednesday mornings upon adjournment and Thursdays beginning at 1:30 p.m. The committee's designated meeting room is Senate Committee Room 354. Occasionally, the committee meets in a different room to accommodate larger crowds or the needs of other committees. Changes to the committee's regular schedule are announced on the Senate floor prior to adjournment. Schedule changes will also be posted on Twitter by the committee staff. If you wish to receive Twitter updates, go to http://twitter.com/cohealthcomm and follow the committee.

Joint Meetings with the House Public Health Care and Human Services Committee and House Health, Insurance, and Environment Committee

The SMART Government Act requires the House and Senate Health committees to hold annual hearings with the Department of Public Health and Environment, Department of Human Services, and Department of Health Care Policy and Financing. At the hearings, the departments must present their annual performance plan, regulatory agenda, and requested budget. The hearings must be held between November 1, 2016, and January 11, 2017. The House Health, Insurance, and Environment and Public Health Care and Human Services Committees will meet jointly with the Senate Health and Human Services Committee to conduct these hearings. During the legislative session, joint meetings of the House and Senate Health committees will be held on Thursdays, at 1:30 p.m., and on Fridays, as needed.

Stakeholders

The following entities are stakeholders that regularly appear before the General Assembly regarding health and human services issues:

- *Department of Health Care Policy and Financing.* The Department of Health Care Policy and Financing is responsible for administering or supervising all public assistance and welfare activities in Colorado, including Medicaid, the Children's Basic Health Plan, the Colorado Indigent Care Program, and the Old Age Pension Health and Medical Program. The department also performs functions related to improving the health care delivery system.

- *Department of Human Services.* The Department of Human Services is responsible for administering or supervising all non-medical public assistance and welfare activities in Colorado, including food stamps, child welfare services, rehabilitation programs, alcohol and drug treatment programs, and programs for the aging.

- *Department of Public Health and Environment.* The Department of Public Health and Environment oversees the following divisions: Air Pollution Control, Water Quality Control, Hazardous Materials and Waste Management, Consumer Protection, Disease Control and Environmental Epidemiology, Prevention Services, Health Facilities and Emergency Medical Services, and Emergency Preparedness and Response.

- *Department of Regulatory Agencies.* The Department of Regulatory Agencies oversees Colorado's businesses and provides consumer protection services. It houses the state's health professions licensing boards and the Division of Insurance, which regulates health, auto, and property insurance companies statewide.

- *The Arc of Colorado.* The Arc of Colorado is a statewide private nonprofit volunteer organization that provides support and advocacy for people with intellectual and developmental disabilities and their families. The Arc of Colorado and all local chapters are affiliated with The Arc of the United States.

- *Center for Improving Value in Health Care.* The Center for Improving Value in Health Care, often referred to as CIVHC, administers the Colorado All Payer Claims Database, which offers comprehensive health care cost, quality, and utilization claims data.

- *Colorado Association of Health Plans.* The Colorado Association of Health Plans is a membership organization that supports the growth and development of health-delivery systems to provide access to high-quality, cost-effective health care to the citizens of Colorado.

- *Colorado Behavioral Healthcare Council.* The Colorado Behavioral Healthcare Council (CBHC) is the statewide membership organization for Colorado's network of community behavioral health providers. CBHC is composed of 27 members who work together to provide comprehensive behavioral health and psychiatric services to the entire state.

- *Colorado Coalition for the Medically Underserved.* The Colorado Coalition for the Medically Underserved consists of 27 individual behavioral health entity members, including community mental health centers, specialty clinics, managed service organizations, and behavioral health organizations.

- *Colorado Community Health Network.* The Colorado Community Health Network represents the 18 community health centers in Colorado.

- *Colorado Consumer Health Initiative.* The Colorado Consumer Health Initiative is a statewide, nonpartisan, nonprofit coalition of organizational and individual members that acts as a representative of the policy and advocacy priorities of its members at the legislature and in the community to influence and shape effective health care policy on behalf of consumers.

- *Colorado Cross-Disability Coalition*. The Colorado Cross-Disability Coalition is a nonprofit organization which advocates for basic civil and human rights for people with disabilities.

- *Colorado Health Foundation.* The Colorado Health Foundation provides grants to not-for-profit organizations that focus on encouraging healthy living.

- *Colorado Health Institute.* The Colorado Health Institute is a nonprofit corporation established to serve as a comprehensive source of health data resources and policy analysis for policymakers, health planners, the business and nonprofit communities, advocacy and consumer groups, health care providers, foundations, and the media.

- *Colorado Hospital Association.* The Colorado Hospital Association represents 100 hospitals and health systems throughout Colorado, and is a resource on health issues, hospital data and trends for the media, policymakers, and the general public.

- *Colorado Medical Society.* The Colorado Medical Society is an association of physicians and is the advocate of its physician members, acting as a conduit for continuing medical education and a physician liaison with managed care and health maintenance organizations and health insurance providers.

- *Colorado Regional Health Information Organization.* The Colorado Regional Health Information Organization, often referred to as CORHIO, is a nonprofit dedicated to improving health care through health information exchange.

- *Colorado Rural Health Center.* The Colorado Rural Health Center is Colorado's nonprofit State Office of Rural Health. It works with federal, state, and local partners to offer services and resources to rural healthcare providers, facilities, and communities.

- *Colorado Trust.* The Colorado Trust is a health foundation dedicated to achieving health equity. The mission of the trust is advancing the health and well-being of the people of Colorado.

- *Connect for Health Colorado.* Connect for Health Colorado is the state-based health insurance exchange created to comply with the Patient Protection and Affordable Care Act. The exchange is a statutorily created nonprofit organization and is not a part of any state agency.

- *Mental Health America of Colorado.* Mental Health America of Colorado is the state's leading mental health advocacy organization. The mission of Mental Health America of Colorado is serving the people of Colorado by collaborating with strategic partners to promote mental health, expand access to services, and transform systems of health care.

- *Oral Health Colorado.* Oral Health Colorado is a nonprofit organization that develops and promotes strategies that achieve optimal oral health for all Coloradans.

- *The Public Health Alliance of Colorado.* The Public Health Alliance of Colorado is a collaborative of ten public health organizations that share resources, administrative support, and communications. The mission of the Alliance is to strengthen public health in Colorado by building capacity within the participating organizations as well as connecting its members.

Glossary of Frequently Used Terms

Accountable care collaborative (ACC): Colorado's new Medicaid program intended to improve enrollees' health while reducing health care spending by rewarding positive health outcomes rather than a high volume of service. The three building blocks of the ACC are: Regional Care Collaborative Organizations (RCCOs) that help coordinate care; Primary Care Medical Providers (PCMPs) that serve as medical homes; and a Statewide Data and Analytics Contractor (SDAC), which provides data and metrics.

Accountable care organization (ACO): A relatively new health care delivery model being tested in Colorado and across the country in Medicare and the private market. An ACO is comprised of networks of providers that coordinate the health care of their patients. An ACO requires providers to work together toward the goal of improving the quality of care and reducing

health care costs. ACOs that save money while meeting quality targets keep a portion of the resulting savings.

Adults without dependent children (AwDC): A Medicaid eligibility category used to describe a population eligible for Medicaid due to Medicaid expansion efforts. AwDC whose household income does not exceed 133 percent of the Federal Poverty Level may be eligible for Medicaid.

Affordable Care Act (ACA): The ACA is also known as the Patient Protection and Affordable Care Act or health care reform.

All-payer Claims Database (APCD): The APCD is a secure database that includes insurance claims data from commercial health plans, Medicare, and Medicaid in Colorado. This information is used to provide transparent price, quality, cost of care and utilization information across Colorado.

Amendment 35: The 2004 voter-approved amendment to the Colorado Constitution to expand access to health care and funding for prevention programs by increasing the sales tax on tobacco products.

Block grant: A lump sum of federal money given to state and local governments for specific purposes.

Bundled payment: A payment model that provides a single payment to a provider, or a group of providers, for all health care services associated with a defined episode of care. The episode may be for a specific condition (diabetes), event (heart attack), or medical procedure (hip replacement). Most episodes of care have a reasonably well-defined beginning and end, but for management of chronic conditions, episodes are defined as all condition-related services in a certain period of time (for example, 12 months).

Capitation: A contractual arrangement between a purchaser (employer or the state) and a health plan in which the health plan agrees to provide a specified range of services to enrollees for a negotiated prospective per member per month (PMPM) payment as opposed to paying on a fee-for-service basis for individual services provided.

Case (care) management: A process used by public and private health insurers and providers to manage the care of high-cost, high-need individuals. Care is coordinated by a case manager to ensure that needs identified through a functional assessment are in alignment with authorized supportive services.

Categorical eligibility: The groups of people eligible for Medicaid: children, pregnant women, adults in families with dependent children, people with disabilities, and the elderly.

Centers for Disease Control and Prevention: The federal agency that focuses on preventing and controlling disease, injury, and disability.

Centers for Medicare and Medicaid Services (CMS): The federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.

Children's Health Insurance Program (CHP+): The federal and state low-cost health insurance program for children and pregnant women who do not qualify for Medicaid but whose families do not earn enough to afford private insurance.

Chronic care: Medical services for people with an illness that lasts a long time or recurs.

COBRA (Consolidated Omnibus Budget Reconciliation Act): 1986 federal legislation that enables qualified individuals who lose their jobs to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. COBRA applies to firms with more than 20 employees. Qualified individuals, who can include retirees, spouses, former spouses, and dependent children, are required to pay the full amount of the standard premium of the plan in which they were enrolled while employed.

Colorado Benefits Management System (CBMS): The integrated system for determining eligibility and calculating benefits for state-supervised assistance programs such as Medicaid, food stamps, and Temporary Assistance for Needy Families (TANF).

Colorado Child Care Assistance Program (CCCAP): Administered by counties, CCCAP provides child care assistance to families that are working, searching for employment, or are in training, and families that are enrolled in the Colorado Works Program and need child care services to support their efforts toward self-sufficiency.

Colorado Health Benefit Exchange (COHBE)/Connect for Health Colorado (C4HCO): The Colorado health insurance marketplace created by legislature in 2011 where individuals and small businesses can buy ACA-qualified health benefit plans that meet certain benefit and cost standards.

Colorado Indigent Care Program (CICP): A state-administered program that provides partial reimbursement to some health care providers who provide a significant amount of health care to the state's uninsured or underinsured populations with incomes up to 250 percent of the Federal Poverty Level.

Community-based services: Designed to help older people remain in their homes. Services may include: home health aides, home-delivered meals, and visiting nurse services.

Community-centered board (CCB): A private, nonprofit organization designated in statute as the single entry point into the long-term services and supports system for persons with developmental disabilities.

Community mental health centers (CMHCs): Community-based mental health centers that provide mental health services to low-income, non-Medicaid eligible individuals. Fees are often set on a sliding-scale based on income. Services are subject to available appropriations.

Consumer-directed health plans: Health plans that typically have high deductibles and are coupled with consumer-controlled savings accounts used to pay for services not covered by the plan. The aim is to make patients more sensitive to the high cost of care.

Continuum of care: The medical, social, rehabilitative, residential, and supportive needs of people who are frail or chronically ill.

Coinsurance: The percentage of the cost of medical services not covered by the insurer and thus must be paid by the patient.

Copayment: A flat amount paid by a consumer when a medical service is rendered by a participating provider in a health plan.

Cost-sharing: Any contribution consumers make towards the cost of their health care as defined in their health insurance policies.

Cost-shifting: Occurs when some payers are charged more for medical services to offset underpayments by other payers.

Deductible: Fixed amount that must be paid by a patient before a health plan begins to cover other services.

Defined benefit: Plan under which health services are standardized and guaranteed, such as in Medicare.

Dual eligible: Lower-income Medicare beneficiaries who also are eligible for some Medicaid benefits, or help with Medicare out-of-pocket expenses.

Electronic medical record: A medical record in digital format.

Employee Retirement Income Security Act (ERISA): The 1974 federal law that regulates most private employee health plans.

Employer mandate: Requires employers to provide health insurance benefits to their employees.

Essential health benefits: The comprehensive package of items and services that must be offered by insurers offering plans both inside and outside of the health insurance marketplace. Essential health benefits must include items and services within at least the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Fee-for-service: Method of paying for health care services based on the actual care delivered.

Federal Poverty Level (FPL): A measure of income level issued annually by the federal Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits.

Formulary: List of medications covered by a health insurance plan.

Guaranteed issue: Requires health plans to accept all applicants even if they have a preexisting condition.

Health coverage tax credits: Refundable tax credit designed to help certain individuals pay for premiums.

Health Insurance Portability and Accountability Act (HIPAA): Federal law that provides some protection for employees and their dependents to renew health insurance. The law also spells out rules to protect the privacy of health care information.

Health maintenance organization (HMO): Managed care plan that gives members comprehensive health care services through a network of providers.

Home health care: Care delivered at home that includes such services as skilled nursing, social services, and occupational therapy.

Long-term care: Health and social services for people with permanent disabilities or chronic illnesses. Care may provided in a residential facility, at home, or elsewhere in the community.

Means-testing: The use of income or assets to determine eligibility for programs.

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. Each state has choices in program design, therefore, Medicaid varies state by state.

Medicaid expansion populations: Those populations eligible for Medicaid as a result of expanding Medicaid eligibility guidelines to include parents of qualified children, adults without dependent children (AwDC), and working disabled individuals. Most recently, Senate Bill 13-200 expanded Medicaid for parents and all AwDC to 133 percent of the Federal Poverty Level.

Medicaid waivers: An official agreement between the Centers for Medicare and Medicaid Services and a state that allows the state to offer additional coverage to specific Medicaid-eligible populations, as well as expanded coverage to populations that may not otherwise be eligible for Medicaid. Waivers include special terms and conditions that define the strict circumstances under which the state may provide additional coverage. Currently, coverage to disabled adults is provided through Home- and Community-based Services (HCBS) waivers. HCBS waivers provide home- or community-based care as an alternative to institutional care. The state currently has waivers in place to provide additional coverage to the following groups of children: disabled children who would otherwise be ineligible for Medicaid due to excess parental income and/or resources; children with a medical diagnosis of Autism; and children with severe developmental disabilities or delays. Additional waivers provide habilitative services for children and youth in foster care who have a developmental disability and extraordinary needs, and Medicaid benefits in the home for children with a life-limiting illness.

Medicare: Federal health program for people 65 and older and the disabled. Part A provides inpatient-hospital coverage; Part B, outpatient coverage, including doctors' visits; Part C, hospital and doctors' expenses, administered through private plans called Medicare Advantage; and Part D, stand-alone prescription drug coverage.

Medicare advantage: Medicare benefits offered through private plans rather than through the traditional fee-for-service plan.

Medicare supplemental insurance (MEDIGAP): Sold by private insurance firms, these policies fill in the "gaps" of Medicare fee-for-service coverage, such as co-pays.

Mental Health Parity Act: Federal law that prohibits health plans with more than 50 employees, including both self-insured and fully-insured plans, from imposing caps or limits on mental health or substance abuse treatment that are more restrictive than those on medical or surgical benefits. State law also prohibits individual, small group, and large group health plans from imposing caps or limits on mental health or substance abuse treatment that are more restrictive than those on medical or surgical benefits.

Open enrollment: The specific time of year that most employees and individuals sign up for health coverage through either an employer, a broker, or the state health care exchange.

Preferred provider organization: Network of providers who contract to deliver care to health plan enrollees on a fee-for-service basis, but at discounted rate.

Self-insured plan: A group plan in which employers assume the financial risk for covering employees, rather than buying insurance from a commercial carrier. A third-party administrator or insurer typically provides administrative services. Self-insured plans are not regulated by the Division of Insurance.

Small group market: Firms with fewer than 50 employees can buy health coverage through this state-regulated market. The rules vary from state to state.

Social Security Disability Insurance (SSDI): Government assistance, financed through Social Security taxes, to people permanently disabled and unable to work, and who previously paid Social Security taxes.

State mandate: State coverage laws requiring private insurers to cover specific services or reimbursement for specific providers.

Supplemental Security Income (SSI): A federal income supplement program funded by general tax revenues that provides cash assistance to help aged, blind, and disabled people, who have little or no income.

Uncompensated care: Health care that is provided but not paid for by the patients or by insurance. Providers and the federal government generally incur the costs.

Underinsured: People who are insured, but nevertheless face big costs or limits on benefits.

Glossary Sources

- Colorado Department of Health Care Policy and Financing glossaries and program pages retrieved from www.colorado.gov.
- Colorado Department of Human Services glossaries and program pages retrieved from www.colorado.gov.
- *Health Reform Glossary*, Henry J. Kaiser Family Foundation, retrieved from www.kff.org.
- *Health Words 2015*, Colorado Health Institute, retrieved from www.coloradohealthinstitute.org.

- United States Centers for Medicare and Medicaid glossaries retrieved from www.cms.gov and www.healthcare.gov.