Summary of Legislation
2024

Health Care and Health Insurance

Introduction

Many pieces of legislation regarding health care and health insurance made their way through the 74th General Assembly. Most of the legislation fell into the following categories: removing barriers to treatment, and licensing requirements.

Removing Barriers to Treatment

The legislature introduced bills to increase coverage of and eligibility for several specific health care services including biomarker testing, doula services, and substance use disorders. House Bill 24-1045, for example, requires an insurance carrier to reimburse a licensed pharmacist prescribing or administering medication-assisted treatment. The act specifically prohibits an insurance carrier that provides coverage for a drug used to treat a substance use disorder under a health benefit plan from requiring prior authorization for the drug based solely on the dosage amount. Senate Bill 24-124 increases health insurance coverage for biomarker testing by requiring all large-group health benefit plans to provide coverage for biomarker testing to guide treatment decisions if the testing is supported by medical and scientific evidence. Senate Bill 24-175 requires large employer health benefit plans to cover doula services to the extent practical and with the same provider qualification requirements as required by Medicaid.

The legislature also passed less service-specific legislation that seeks to increase health insurance coverage and eligibility. For example, House Bill 24-1229 changes the requirements for people in need of long-term care to become presumptively eligible for Medicaid by removing the requirement for a level of care assessment and allowing the Department of Health Care Policy and Financing (HCPF) to collect any information required for federal authorization. Additionally, House Bill 24-1149 establishes exceptions from prior authorization requirements, including fraudulent or misrepresented requests, removal of prescription drugs from the market, and availability of a generic equivalent on a carrier's drug formulary. Carriers and private utilization review organizations are further prohibited from denying an approved surgical procedure or related claim. There was also an attempt to address provider-administered drugs with House Bill 24-1010, which was considered but ultimately failed. The bill would have prohibited insurance carriers from:

- requiring that provider-administered prescription drugs be dispensed only by specific network pharmacies;
- limiting coverage for provider-administered prescription drugs due to an insured person's preferred participating provider;
- imposing additional fees or copays on provider-administered prescription drugs due to an insured person's preferred participating provider; or

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- requiring that providers bill certain provider-administered prescription drugs under the pharmacy benefit rather than the medical benefit without consent.

The legislature also focused on Medicaid coverage and eligibility with House Bill 24-1400, which authorizes HCPF to seek federal authorization to not require additional verification during a Medicaid member's eligibility reenrollment process if information about the member's income or assets is not verified through a federally approved electronic data source. Additionally, Senate Bill 24-093 deems that if person is disenrolled from their health plan and starts receiving coverage from a new carrier for an existing course of treatment that meets select criteria, the new carrier must cover the treatment as an in-network benefit for up to 90 days. The legislature also paid attention to prior authorization for Medicaid recipients with the passage of Senate Bill-110. The act prohibits HCPF from requiring an adult to be prescribed an antipsychotic prescription drug that is included on the preferred drug list and used to treat a mental health disorder or mental health condition if:

- During the preceding year, the adult was prescribed and unsuccessfully treated with an antipsychotic prescription drug that is included on the preferred drug list and used to treat a mental health disorder or mental health condition and for which a single claim is paid; or
- the adult is stable on an antipsychotic drug used to treat a mental health disorder or mental health condition that is not included on the preferred drug list.

Finally, the passage of House Bill-1258 creates protections for individuals who may be losing health insurance coverage due to an insurance provider leaving the state. More specifically, if a person is forced to change carriers because a small group plan carrier left the market, the bill requires the new carrier to credit all out-of-pocket expenses paid by the person in the given plan year towards their new deductible and out-of-pocket maximum unless doing so will cause the new carrier to become insolvent.

Licensing Requirements

The General Assembly also focused some of its efforts on addressing licensing requirements and regulations in the state, specifically for hospitals and clinics. Senate Bill 24-223 modifies existing requirements regarding Colorado fertility clinics and sets requirements for identity disclosure of gamete donors when the gamete recipient is in Colorado. Additionally, it requires licensees to submit documentation that shows compliance with licensing requirements initially and upon license renewal.

Under current law, critical access hospitals are licensed as general hospitals with the Department of Public Health and Environment (CDPHE). Senate Bill 24-121 requires critical access hospitals to be licensed separately, and directs CDPHE to adopt rules for this new license. Senate Bill 24-121 also places responsibility on the State Board of Health to promulgate rules concerning the licensure of critical access hospitals.