

CASE STUDY

Experiences Battling Debt Drive Reform of Hospital Financial Assistance Laws in Colorado



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COMMUNITY CATALYST and THE COLORADO CENTER ON LAW AND POLICY

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Introduction

IN JUNE 2021, the Colorado General Assembly passed a groundbreaking law to protect hospital patients from the hardships caused by medical debt. This legislation — *HB21-1198: Health-care Billing Requirements for Indigent Patients* — is a comprehensive response to the experiences of patients and patient advocates attempting to navigate hospital billing practices.

The new law addresses high hospital prices for low-income patients and simplifies the process of applying for financial relief. Additionally, it ensures that hospitals are connecting uninsured patients to Medicaid and other coverage programs when they are eligible, strengthens

patient notification provisions and administrative oversight, and empowers patients to file lawsuits and collect attorney’s fees when collections actions are initiated in violation of their rights under the new law.

This brief tells the story of HB-1198 from conception through passage and the beginning of implementation. It is a story that begins with the experiences of the people in our communities who search in vain for hospital services they can afford, the people who are drowning in hospital bills after a sudden illness or injury, and the people who are suffering long-term financial distress because they were denied access to coverage or financial assistance.

ACKNOWLEDGEMENTS

The stories that informed the policy largely came to the Colorado Center on Law and Policy (CCLP) through organizations and attorneys that represent patients in their efforts to find affordable care and cope with unmanageable health care bills and relentless collections practices. Many communities, organizations and individuals informed the policy, and HB-1198 would not exist without them.

Special recognition is owed to the Colorado Consumer Health Initiative (CCHI), Center for Health Progress, and the Family & Intercultural Resource Center of Summit County (Summit FIRC). CCHI runs a Consumer Assistance Program (CAP) that, at the time HB-1198 was in committee, had helped insured and underinsured Coloradans in 12 Colorado counties fight approximately \$2 million in hospital bills over a three-year period.

Center for Health Progress is organizing Latinx communities in Pueblo, Colorado to champion community priorities in healthcare transformation and hold their local hospitals accountable to community needs. Summit FIRC has worked tirelessly alongside members of their community to find affordable hospital care options, navigate policies that exclude immigrants and their families, and advocate with their local hospital for the financial relief patients desperately need.

Special thanks also go to the dedicated attorneys at Colorado Legal Services and Vedra Law LLC, whose experiences representing clients with medical debt informed our advocacy. Our partners’ critical efforts — building trust and providing expert advocacy in communities — have helped to keep consumer experiences and voices at the center of reforming hospital billing practices and fighting medical debt in Colorado.

EARLY EFFORTS TO ADDRESS HOSPITAL FINANCIAL ASSISTANCE FELL SHORT...

Colorado first passed hospital financial assistance legislation in 2012. As a result of early legislative efforts, Colorado hospitals were required to provide a discounted rate to low-income uninsured patients. The early legislation also directed hospitals to “offer” to screen patients for eligibility for financial relief but only “if possible” and to offer a “fair” payment plan before sending patient debt to collections. Finally, the legislation required hospitals to post information about financial assistance in patient waiting areas as well as online.

For many years after the 2012 legislation passed, healthcare advocates pressed the Colorado Department of Public Health and Environment to issue regulations implementing the statute. One of the problems was the lack of guidance around the statutory terms “if possible” and “fair,” which made it challenging to hold hospitals accountable. That advocacy included championing another bill in 2014 that dealt with the establishment of standards for uniform implementation of hospital financial assistance.

Ultimately, however, regulations never moved forward, and in light of unrelenting problems with hospital billing, CCHI and CCLP began exploring other advocacy options, including the possibility of legislation.

POLITICAL PROSPECTS FOR FINANCIAL ASSISTANCE LEGISLATION IN 2021 WERE FAVORABLE BUT MIXED...

The Colorado context in 2021 presented both opportunities and challenges for advancing

hospital financial assistance legislation. On the opportunity side, health care has been a priority issue for Colorado Democrats which have been in the majority in both state houses since 2019, and for Governor Jared Polis, who established a cabinet-level Office of Saving People Money on Health Care, headed by Colorado’s Lieutenant Governor. Also, strong Black and Latino caucuses have effectively championed greater focus on the barriers to health and economic security that disproportionately impact communities of color — including in the health care context.

In this environment, several big health care proposals have become law in recent years. A few examples of successful legislation:

- Protecting consumers against surprise out-of-network bills
- Providing state-subsidized health insurance to immigrants that can’t establish lawful presence
- Addressing prescription drug costs through a new affordability board with price setting authorities
- Creating a standardized health insurance plan, as well as giving Colorado’s Division of Insurance the authority to conduct rate hearings if carriers are unable to offer the standardized plan at target prices.

In line with the administration’s focus on cutting health care costs, Colorado’s Department of Health Care Policy and Financing (HCPF) has expressed support of efforts to reign in hospital prices, to require financial reporting from hospitals, and to challenge hospitals to invest more in community health. Ultimately, a friendly attitude toward stronger hospital financial assistance requirements within HCPF helped ensure that we had access to helpful technical assistance and data, as well as political support from the administration.

But the political context also presented challenges. First, while there is certainly frustration among state legislators with ballooning hospital profits and their impact on Colorado families, that frustration coexists with hesitancy or even outright hostility toward proposals that might reduce hospital revenues or increase hospitals' administrative costs. This has much to do with the strength of the hospital lobby in Colorado — but also relates to concerns about how policy reforms may impact the sustainability of rural and critical access hospitals.

Furthermore, concerns about reducing hospital revenues were particularly tricky to navigate in the lead up to and during the 2021 legislative session for a couple reasons. First, the devastating COVID-19 pandemic had placed unprecedented strain on hospital resources, a fact that hospitals and many legislators highlighted in public debate over critical affordability reforms. Second, the legislature became embroiled in the debate over a public option proposal, which included rate-setting provisions that hospitals and provider groups characterized as unsustainable.

Finally, we knew that the bill we needed in Colorado would impact the business practices, not only of hospitals, but of independent anesthesiologists, radiologists, physicians, and other providers that work in hospitals, as well as debt industry stakeholders that collect on hospital debt. To get the bill through, we would have to successfully navigate pushback from this broad, well-resourced, and well-connected set of stakeholders.

DATA POINTS TO FINANCIAL TOXICITY OF HEALTH CARE AND IMPACT OF RACISM...

While the political environment was mixed, the need for legislation to bring hospital bills under control was only growing clearer. Stories poured in about people struggling with hospital billing practices. Those stories were backed up by troubling data.

According to the 2019 Colorado Health Access Survey (CHAS), one in five Coloradans (22.5%) decided to forgo care due to cost. Nearly one in five (18.1%) had trouble affording their health care bills. But the experience has been even worse for Coloradans impacted by structural racism. The impacts of racist policy choices made throughout the 20th century — including the exclusion of domestic and farm workers from Social Security, restrictive covenants on New Deal subsidized housing, redlining, and predatory policing in neighborhoods of color — have combined with today's laissez faire economic policies to create persistent disparities in access to income, wealth, and other critical resources for people of color in Colorado and across the nation. Illustrating this context, the survey showed Black Coloradans were nearly twice as likely to have had trouble paying a medical bill than white Coloradans.

The data on medical debt told a similar story. According to an Urban Institute Study, 13% of all Coloradans had medical debt in collections, while nearly one in four Coloradans (23%) from communities of color were struggling with medical debt in collections. This inequity is a consequence of the resource and wealth gaps created by racist policies and practices and leads to still greater inequities in communities already experiencing high levels of financial distress.

While HB1198 was moving through the legislative process during the 2021 session, CCLP received funding to survey Coloradans about their experiences with hospital bills. The study surveyed 441 Colorado residents who had received care in a Colorado hospital in the previous 12 months. While we could not use the study to support legislative work due to funding restrictions, CCLP pursued the research to inform implementation of the new law, in the event it passed, and to influence the ongoing dialogue about the impact of medical debt in Colorado. Ultimately, the data has helped to supplement our understanding of Coloradans' experiences with hospital billing practices and debt and highlights the importance of new provision past under HB1198.

Key findings:

- 77% said the cost of healthcare was very or somewhat unaffordable with 50% saying it was very unaffordable
- 71% of respondents without health insurance said they did not know Colorado hospitals were required to provide financial assistance
- Only 21% of respondents said that the hospital offered them a payment plan
- 64% of respondents had trouble or were late paying their hospital bills
- 84% percent of respondents that had trouble paying a hospital bill struggled to afford other monthly expenses
- 72% of respondents who had trouble paying a hospital bill were sent to a collection agency

COMMUNITY EXPERIENCES ILLUMINATE SYSTEMIC CHALLENGES AND DRIVE LEGISLATIVE PRIORITIES...

For CCLP, building an effective hospital financial assistance policy required more than an awareness of what the public data sources were telling us. We needed to understand the lived experiences of people impacted by hospital debt, especially of those from communities experiencing disproportionate impacts. To do that, we coordinated with community-based partners like Center for Health Progress, the Consumer Assistance Program at CCHI, and Summit FIRC. These are groups that do critical work in community organizing around hospital accountability or helping community members find care and fight exorbitant bills.

Our intention was to work with these partners to bring community members to the policy-making table on this issue so that they could be the drivers from start to finish. CCLP knew, however, that such an involved process with community members would require funding to support community organizations' mobilization efforts, as well as critical supports to ensure inclusive community meetings – such as childcare, technology support for virtual participation or transportation, language access, and compensation for participants.

CCLP was ultimately unsuccessful in fundraising adequate resources to support our partners and community leaders at such an involved level. So, we used the funding we were able to secure to support our partners' efforts compiling information about their community members' experiences with hospital billing, reviewing and providing feedback on the bill drafts and amendments we developed, and supporting their community members' participation in the advocacy process.

At the policy development stage which took place during the summer and fall of 2020, CCLP ultimately had in-depth conversations with representatives of nine organizations¹ serving over 15 different rural, suburban, and/or urban counties. The experiences of community partners demonstrated that hospital noncompliance ran rampant. Low-income patients were not getting the discounted rates required under the law and they were not offered payment plans before they were sent to collections.

According to community partners, even when patients were aware that they could apply for financial assistance or sought out the opportunity, they regularly hit a wall. Commonly, patients could not find any information about financial assistance or how to apply. Beyond that, burdensome paperwork requirements — and hospitals' failure to have a clear and navigable set of eligibility criteria — effectively denied access to those who should have qualified for assistance.

Community partners also identified that clients who should have been able to enroll in Medicaid commonly ended up in collections. They reported that low-income patients with private insurance would end up in collections due to high deductible or other cost-sharing bills, with little to no recourse, because financial assistance only applied to the uninsured.

Advocates also shared challenging experiences with bills from independent providers that provided care in hospital settings. Patients and their advocates reported that they had even less leverage to negotiate manageable payment arrangements with these providers, as they were not subject to any financial assistance requirements at the state or federal level.

Finally, at the debt collection stage, consumer law advocates and community partners reported that hospitals sent insured patients to collections without ever billing the insurance carrier,

that patients had insufficient access to legal assistance, and that patients had little to no recourse when ending up in collections after a hospital failed to provide the financial assistance or payment plan required under the law.

Through close collaboration with our partners, we identified the following priorities for a legislative solution to the hospital billing challenges our communities were facing:

- Making bills for hospital care affordable for low-income patients
- Ensuring screening processes that would connect people to public coverage or discounts
- Giving patients a fair chance to pay their hospital bills before they are sent to collections
- Simplifying and streamlining the process of applying for hospital financial assistance
- Establishing strong mechanisms for enforcing hospitals' financial assistance obligations

Based on these priorities, CCLP developed early drafts of the bill which was eventually introduced in the Colorado General Assembly in March 2021 by House sponsor Representative Iman Jodeh as HB21-1198. Ultimately, our close work with community partners, months in advance of the legislative session, helped build the policy we needed — and the arguments that would prove essential to its passage.

NEW LEGISLATION ENACTS COMPREHENSIVE REFORMS TO HOSPITAL FINANCIAL ASSISTANCE

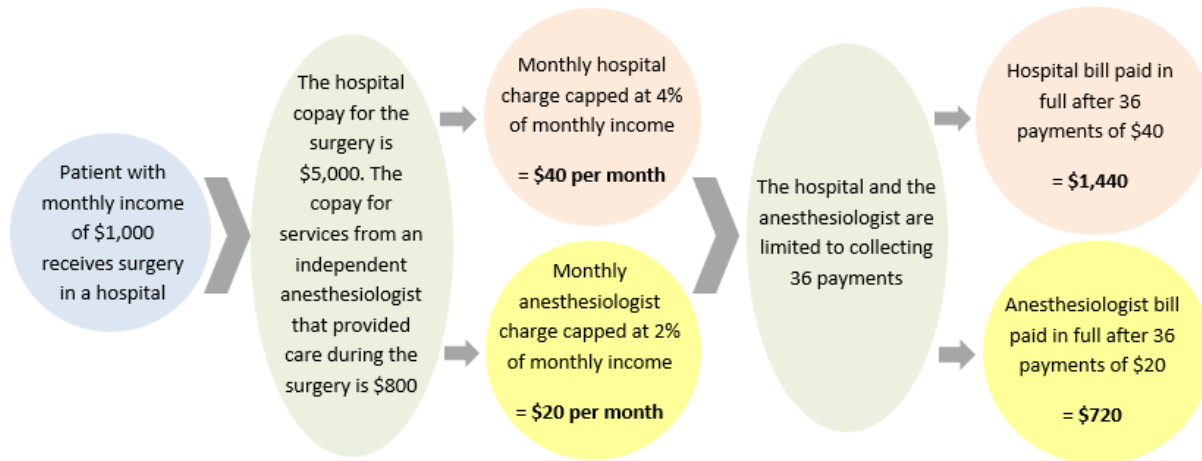
The key components of the bill we developed with community partners are described in this section. They include transparent hospital discounts, the requirement that hospitals screen

patients for eligibility for public coverage and hospital discounts, simplified application processes, and enforcement.

36-payment limit apply to low-income patients, whether they are uninsured or are insured and obligated to pay a deductible or other cost-sharing obligation under their plan.

TRANSPARENT DISCOUNTS ON HOSPITAL CARE

The legislation requires discounts on hospital care for low-income patients². The discount formula has three elements.



EXAMPLE: INSURED PATIENT UNDERGOES SURGERY

First, it provides that monthly bills from a hospital or ER cannot exceed 4 percent of the patient's monthly income and that monthly bills from hospital-based providers that bill separately cannot exceed 2 percent of monthly income ("the 4%/2% standard").³

Second, the legislation requires those facilities and providers to consider bills paid in full when the billed amount is paid, or once the patient makes 36 payments, whichever happens first.

Third, the legislation caps the amount that can be billed to patients who qualify for discounts. The Colorado Department of Healthcare Policy and Financing (HCPF) is charged with setting and publicly posting those rates, which must approximate the rates paid by Medicare and Medicaid.

While the rate caps apply only to uninsured patients, both the 4%/2% standard and the

SCREENING FOR PUBLIC COVERAGE AND HOSPITAL DISCOUNTS

The legislation also requires hospitals to screen all uninsured patients for eligibility for public coverage and hospital discounts unless the patient makes an informed decision to decline screening. Hospitals must also screen every insured patient who requests to be screened.

The public coverage programs that hospitals must screen patients for include Medicaid, Medicare, the Colorado Health Plan *Plus* (Colorado's CHIP program), and emergency Medicaid. The discount programs hospitals must screen patients for include the Colorado Indigent Care Program⁴, and the new discount program under HB-1198.

Screening is defined in statute as involving an individualized assessment of the patient's

circumstances to determine what they are qualified for and steps that will connect the patients to appropriate programs. In addition, the legislation directs HCPF to identify the screening process in rule.

Finally, it requires the CICIP application, noticing, and appeals processes to be aligned with those processes for the new discounts available under HB-1198. The goal is that people should be able to use one form and provide proof of income

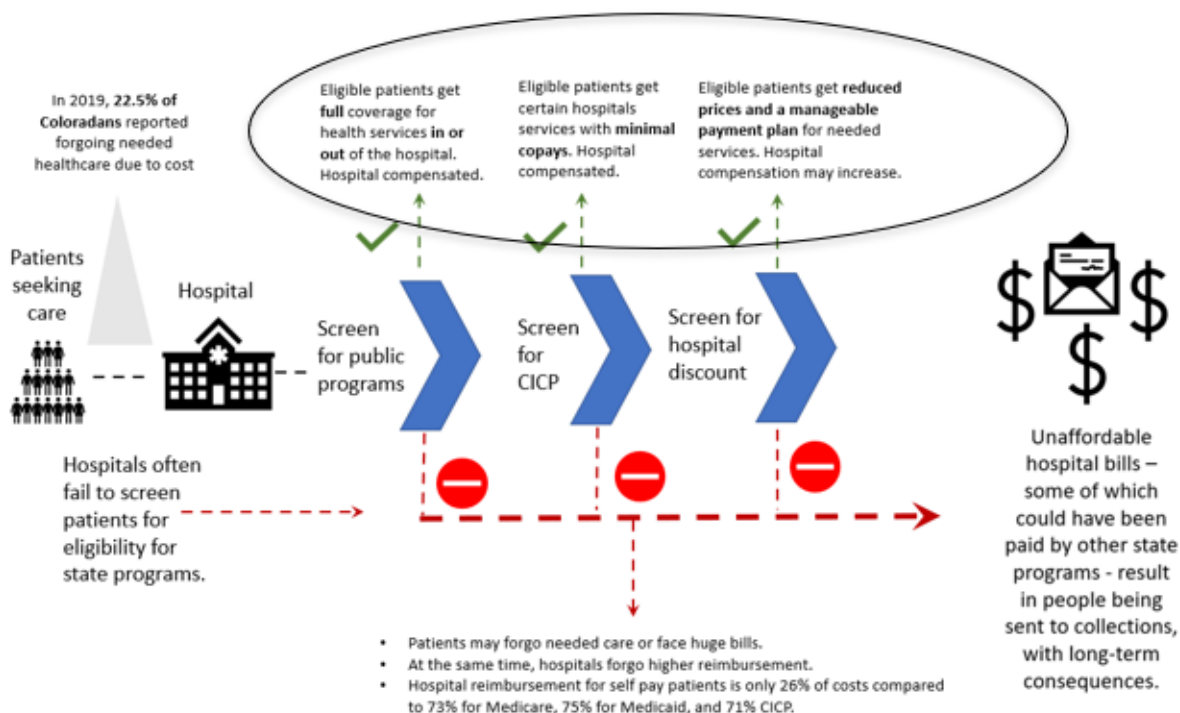


DIAGRAM: IMPACT OF HOSPITAL-BASED SCREENING

SIMPLIFIED APPLICATION PROCESS FOR DISCOUNTS

For many of our partners, the key to community members accessing critical financial assistance was in eliminating the confusing and burdensome application requirements imposed by hospitals. The approach our coalition prioritized was simplicity and uniformity across hospitals.

To accomplish that the law requires HCPF to develop a uniform application for hospital discounts that all hospitals must use. It also requires HCPF to determine the income counting methodology that all hospitals must use and the documents all hospital may require to verify income. Further, the legislation directs HCPF to specify uniform notice and appeal requirements for hospital discounts.

once and those who qualify for CICIP will be enrolled into that program and those that only qualify for HB-1198 discounts, will get attached to the HB-1198 program.

ENFORCEMENT

Finally, a core focus of the effort was enforcement. CCLP is hopeful that simplifying and demystifying the discounts people are eligible for and the process they use to apply will help patients enforce their rights though self-advocacy, but we also added several provisions specifically aimed at measuring compliance and enforcing the new law’s provisions.

First, HCPF will have to work with stakeholders to develop an explanation of patient rights under this program and translated that information into

commonly spoken languages. HCPF is required to post this statement online and hospitals will have to post it as well, with a link to it from their homepage. Hospitals will be required to post the statement in patient waiting areas, attach it to billing statements, and explain the information to individuals in their primary language before they leave the hospital. In addition, a link to the HCPF statement must be included in notices sent by a collection agency, attempting to collect on hospital debt.

Next, the legislation requires hospital reporting on financial assistance and billing activities. HCPF will determine what data points they need hospitals to report to measure compliance with the program, and hospitals will be required to report that data by race, ethnicity, primary language, and age so that an assessment can be made of how the program is being experienced across different populations

Next, HCPF must establish an administrative complaint process, through which patients can file complaints about hospital noncompliance. The law requires HCPF to investigate complaints and gives them authority to require corrective action plans and issue fines. Also, the bill requires HCPF to conduct rolling compliance checks of all facilities and providers covered by the legislation.

Finally, the legislation creates a private right of action, which mirrors the cause of action in the federal Fair Debt Collections Practices Act (FDCPA). A private right of action gives individuals the right to file lawsuits and collect damages for violations of their rights. Under the private right of action in HB-1198, if hospitals fail to screen as required under the new law, fail to provide discounts as required, fail to provide a clear statement of charges, or fail to bill someone's insurance before sending them to collections, then the patient can sue the hospital for damages and collect attorney's fees.

DEBT COLLECTION PROTECTIONS

Finally, the legislation adds protections to Colorado's debt collections statute. In cases involving medical debt from a hospital or ER provider, the new provisions prohibit foreclosure on an individual's primary residence or homestead, including a mobile home. They also enhance the notice debt collectors must provide under the FDCPA and give patients who have been sent to collections inappropriately, legal tools to repair damage to their credit, recoup fees and costs, and to get lawsuits or judgments against them dismissed or reversed.

ELIMINATING UNINTENDED BURDENS FOR INDUSTRY AND KEY ARGUMENTS WERE CRITICAL FOR SUCCESS...

Starting in December 2020 and continuing throughout the legislative session in February-June 2021, CCLP met with hospitals, provider groups, or debt collectors more than a dozen times. As a result of our coalition's work during the summer and fall of 2020, we were able to negotiate in those meetings from a place of strength, even when our partners did not have the capacity to be in every meeting. That strength came from having clear arguments, rooted in lived experience, for every policy priority we aimed to advance in the bill.

The strong negotiating position made it easier to find areas of compromise that did not undermine our core priorities. Key areas of compromise focused on reducing administrative burden for hospitals and providers, and massaging new debt collection requirements so they wouldn't conflict with debt collectors' federal obligations.

We were even able to get creative, reducing administrative burden for industry in ways that we are hopeful will make the policy stronger for consumers as well. For example, instead of

having each hospital draft the required statement of patient rights and translate it into commonly spoken languages, the legislation requires HCPF to work with stakeholders to develop and translate the statement and requires all hospitals to use it. We were also able to effectively pitch HCPF's development of uniform program requirements and rates as a method of reducing administrative burden for hospitals.

Work with debt collectors and provider groups, ultimately resulted in those interest groups taking a neutral position on the bill. Our hospital association testified positively about our work with the association with their members, but ultimately remained opposed to the bill over two issues. First, they testified in opposition to rate caps tied to Medicare and Medicaid. The hospitals objected to this based on their position that the rates paid under these programs are inadequate. Second, the association objected to the private right of action for patients.

A few things helped us to overcome their opposition and win on these issues. First, we were able to show legislators the amount of work we had done, with the hospitals, to reduce the number of issues they had with the bill down to two. Second, a few key arguments were helpful. Regarding the rates, we argued that it was important to have HCPF set and publicly post rates to maximize transparency for uninsured patients.

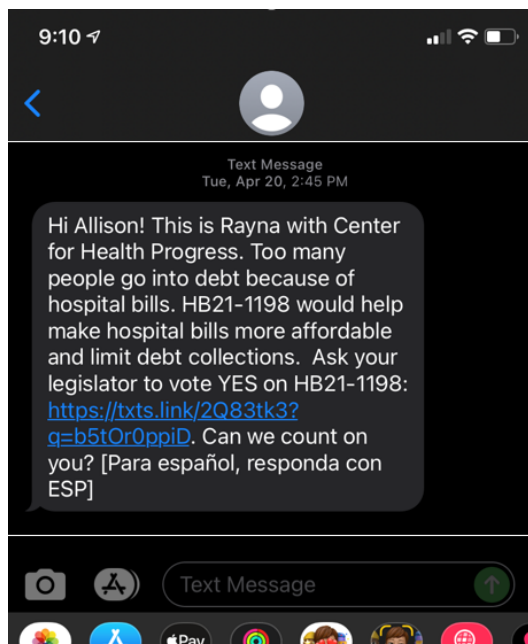
In addition, to alleviate concerns about the impact of the discounts, we pointed to HCPF data that showed self-pay patients were able to cover just 26% of hospitals' reported costs. This was much lower than the average rates of reimbursement under Medicaid and Medicare at 75% and 71% of costs respectively. We also argued that, with more manageable payment obligations under the legislation, self-pay patients may even be able to pay more of the cost of their care.

Regarding the private right of action, we focused on the deterrent effect. We pointed out that the addition of the cause of action under the FDCPA drastically reduced the practices the cause of action made debt collectors liable for. With that information, we were able to effectively portray the cause of action as a mechanism to prevent problems before they happen.

STRONG COMMUNITY SUPPORT AND A PROGRESSIVE-LEANING TRIFECTA WON THE DAY...

Participation in the advocacy effort grew directly out of the process of developing the policy. Because the policy was crafted through a collaborative effort, our community partners were already familiar with the policy and how it would affect their lives or the lives of their clients as the bill was going before the legislature.

CCLP also created several resources to support participation in the advocacy process. We developed an electronic toolkit⁵ with



talking points and FAQs about the policy, template action alerts, our factsheet, sample posts and infographics for social media, and other resources designed to add advocacy capacity for our partners and community members.

With those resources, our partners took a range of actions. Center for Health Progress initiated a text campaign activating their grassroots members to make calls to legislators, Chronic Care Collaborative helped drive 49 engagements with 24 Senators to help the policy advance through the Senate, and the Summit Family Intercultural Resource Center contacted 160 rural partners about supporting the effort. In addition, 16 organizations and nine community members testified orally or in writing before one or more legislative committees.⁶

In the end, HB-1198 passed on a party-line vote with all Democrats in the House and Senate voting to pass the bill and all Republicans in both chambers voting against passage. Governor Polis signed the bill without additional advocacy or controversy on July 6, 2021.

COMMUNITY PRIORITIES ARE CRITICAL AS WE MOVE FORWARD WITH IMPLEMENTATION...

Implementation of HB-1198 will involve rulemaking, development of the statement of patient rights, translation of the statement of patient rights into commonly spoken languages, creation of the uniform application for hospital discounts, and getting the word out to Coloradans.

It is CCLP's priority that patient voices drive the decisions made at the implementation stage, just as that was our priority during the legislative process. To support that outcome, CCLP is working with HCPF to design an inclusive stakeholder process. Additionally, we worked

with our partners to develop a community-focused training on the new law, on the work to be done at implementation, and on how people can get involved.

HCPF's implementation began in the summer of 2021 with the hiring of a contractor to facilitate stakeholder meetings and coordinate the development of draft regulations. Beginning in late October 2021, HCPF established a workgroup that will work with the contractor and HCPF staff to draft proposed regulations and the uniform application. CCLP is on that workgroup, along with a representative from CCHI's Consumer Assistance Program, a rural hospital representative, and a representative from the Colorado hospital association.

Early in 2022, the Department is planning to host at least three large stakeholder meetings, which will be simultaneously interpreted into Spanish, to vet the draft regulations and patient-facing materials. HCPF has told us that at least one of those meetings will be exclusively for community members and advocates.


The training we developed is intended to help community partners feel more prepared to engage in HCPF's stakeholder process. The training introduces the issue, outlines the problems with the old law and the major provisions of the new law, then it covers the major issues that will come up during implementation. The key implementation issues CCLP identified in the training are:

- Making information about patient rights accessible
- Ensuring screening connects patients to coverage
- Developing an accessible application for discounts
- Preventing hospital practices that deter access to discounts

- Ensuring notices enable patients to enforce their rights
- Ensuring appeals enable patients to enforce their rights
- Making the complaint process accessible
- Ensuring hospitals report necessary data


For each issue, the training identifies what the bill does and what is left to be decided during implementation and poses questions to the audience about the issue. (See example slides below.)

CCLP’s training was simultaneously interpreted into Spanish. Recordings of the training can be found online,⁷ as can a follow up survey intended to get participants’ feedback on the effectiveness of the training and their feedback on the implementation issues. CCLP is testing this as a model for supporting broader engagement in administrative level advocacy.



¿Qué debe exigir el HCPF para que la verificación de requisitos realizada por el hospital permita que los pacientes que reúnen las condiciones necesarias obtengan cobertura? / What must HCPF require so that hospital screening connects eligible patients to coverage?

¿Qué anécdotas o experiencias justifican su punto de vista? / What stories and/or experiences are informing your perspective?



Asunto 2: Garantía de que la verificación de requisitos ayude a los pacientes a obtener cobertura / Issue 2: Ensuring screening connects patients to coverage

Lo que exige el proyecto de ley / What the bill requires

- La verificación de requisitos debe servir para que los pacientes que reúnen las condiciones necesarias obtengan cobertura pública / Screening must connect eligible patients to public coverage
- Según la ley, todos los pacientes sin seguro médico tienen derecho a una verificación de requisitos / All uninsured patients have a legal right to screening
- Según la ley, todos los pacientes con seguro médico tienen derecho a una verificación de requisitos si la solicitan / All insured patients have legal right to screening if they request it

Lo que se debe hacer en la implementación / What needs to be done at implementation

- Definir una reglamentación para el proceso que se deben utilizar en los hospitales para verificar si los pacientes reúnen los requisitos necesarios / Establish in regulation the process hospitals must use to screen patients
- Definir el proceso que deben utilizar los hospitales para que los pacientes que probablemente reúnan los requisitos necesarios obtengan cobertura / Establish the process hospitals must use to connect likely eligible patients to coverage
- Reconocer qué constituye una decisión “fundamentada” para rechazar la verificación de requisitos / Identify what qualifies as an ‘informed’ decision to decline screening

LESSONS LEARNED

In conclusion, CCLP can identify a handful of lessons learned from the development, passage, and implementation of HB-1198:

- Involving community partners from the beginning of policy development not only produces stronger policy and stronger arguments, but also contributes to advocacy capacity down the line.
- Engaging with potential opposition early and often can prove advantageous, but settling your priorities with community and the arguments supporting those priorities first is critical.
- Considerations about the feasibility of implementation and how a new law's requirements will be enforced must be front and center during policy development.
- A clear focus on equity is essential for developing effective policy and helps

earn the support of critical legislative champions, particularly leaders in the Black and Latino caucuses

- When the people that face structural oppression and exclusion are involved in policy making, we build better policy. As a policy organization without a grassroots presence, it is important for us to build and nurture transformative relationships with the grassroots organizations that help us connect our work to communities. It is also important for us to invest our time and resources to supplement capacity in community – through education and training, meeting supports, and compensation for community members' time. This requires long term planning for fundraising and coordination with diverse partners.

We seek to incorporate lessons learned to make continuous improvements to our policy work – improvements that better center the strength and expertise of our communities in systems change.

Endnotes

- 1 The organizations we interviewed included CCHI's Consumer Assistance Program, Center for Health Progress, Colorado-Cross Disability Coalition, Chronic Care Collaborative, Tri-County Health Network, Denver Indian Health and Family Services, Lake County Build a Generation, and Towards Justice.
- 2 Patients that are eligible if they have a household income at or below 250 percent of the federal poverty level. The discounts apply for services that the patient is not eligible to receive at a discount under the Colorado Indigent Care Program (CICP). CICP uses federal disproportionate share hospital dollars to provide some reimbursement to hospitals for providing certain services for minimal copays based on income. To qualify for CICP, patients must be Colorado residents, must be citizens or able to establish lawful presence, must be ineligible for Medicaid and Colorado's Children's Health Insurance Program (CHIP) and must be at or below 250% of the federal poverty level.
- 3 The 4%/2% standard aims to put hospital patients in the position of being adequately insured when it comes to hospital care. The Commonwealth definition ties underinsured status to cost-sharing obligations that exceed 10 percent or - for people under 200 percent FPL - 5 percent of household income.
- 4 The Colorado Indigent Care Program (CICP) uses federal disproportionate share hospital dollars to provide some reimbursement to hospitals for providing certain services for minimal copays based on income.
- 5 This toolkit can be viewed in Google doc form at this link: https://docs.google.com/document/d/1Xl2owyc-dEzmcS0AasKJn1LEnTP5aKdz2liEG_Kcxb3g/edit
- 6 Archived testimony can be found here: <https://leg.colorado.gov/watch-listen>. Click on the appropriate committee and search for hearing recordings by date. In the Colorado House of Representatives, HB-1198 was heard in the House Health & Insurance Committee on April 21, 2021, and in the Colorado Senate, it was heard in the Senate Health & Human Services Committee on May 25, 2021.
- 7 <https://www.youtube.com/watch?v=OiidklkrtI&t=5s> (English recording); <https://www.youtube.com/watch?v=EpjOli8R9dM&t=761s> (Spanish recording)