COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

2021 Colorado Health Cabinet Health Policy Summit, hosted by HCPF
Questions & Answers

Fact Sheet February 2021

Overview

The 2021 Colorado Health Cabinet Health Policy Summit, hosted by HCPF, was so successful that over 1,800 people were in attendance and over 400 questions submitted for the presenters and facilitators. Below are answers to the most commonly asked questions to including additional links for more information.

Summit Session's Questions and Answers

MEDICAID PROGRAM QUESTIONS

One of the things I am most concerned about in disparities is culturally competent care in physical health and especially behavioral health. How do we get that covered by Medicaid?
Health First Colorado (Colorado's Medicaid Program) members have comprehensive mental health and substance use disorder services through their regional organization. Behavioral health providers offer members medically necessary behavioral health services, like therapy or medications. Learn more
Recently, HCPF announced expansion of substance use disorder coverage for Health First Colorado members. This expanded coverage will provide members greater assistance on their road to recovery from drug and alcohol addiction. Learn more.
As HCPF develops its health equity focus to address disparities in access and utilization of behavioral health services, we will continue to refine our engagement with regional organizations and providers to ensure that Health First Colorado members from diverse backgrounds receive culturally competent care.

Do all EHRs talk to each other?
Unfortunately, not all electronic health records in 2021 are able to easily exchange data with each other. he federal government has established core data standards, refreshed their five year health IT strategic plan, incentivized the interoperability of these systems, which includes leveraging Health Information Exchanges (HIE), and established federal

interoperability rules that providers, payers, and vendors will need to meet. These are important steps, but more work remains. To help guide this work, Colorado's Office of eHealth Innovation will be refreshing the state's strategic plan this year. They are also leading a number of interoperability projects with the state's HIEs, CORHIO and Quality Health Network (QHN), to bridge this gap in connectivity with an emphasis on connecting rural providers to the HIEs.

Have you considered granting/mini-granting EHR implementation costs for the EHR workflows? Similarly, are there plans to incentivize health systems to prioritize EHR implementation?
Optimizing a provider's workflow as part of their Electronic Health Record (EHR) implementation is critical to the ongoing adoption of these systems. Although funds from the American Recovery and Reinvestment Health Information Technology Act (ARRA HITECH) can't be used for EHR implementations, health information exchanges do provide technical assistance to providers. As for funding, the Hospital Transformation Rural Fund can be used toward EHR implementations and upgrades, and refinement of workflows.

Many mental health professionals don't take insurance because of low reimbursement rates and complicated billing procedures. How can we address this?
Yes, these are both significant concerns that have been identified through the state's Behavioral Health Task Force. The state is working on an all-payer behavioral health rate analysis to better understand the challenge. HCPF also has a budget request to expand the Medicaid finance technology to include all other state payers.

Does the [behavioral health] plan cover services for youth?
The governor's website for Behavioral Health Reform includes the Behavioral Health Blueprint as well as reports from the Behavioral Health Task Force subcommittees, including the Children's Subcommittee. Both address services and youth directly.

The State Innovation Model finished in 2019. What's been happening since then to expand our behavioral health workforce?
The governor's website for Behavioral Health Reform includes the Behavioral Health Blueprint as well as reports from the Behavioral Health Task Force subcommittees, including the Children's Subcommittee. Both address services and youth directly.

How do rural hospitals and other private providers collaborate with FQHCs in their community?
Most critical access hospitals in rural areas have hospital-based or hospital-associated rural health clinics (RHCs). RHCs provide primary care and behavioral health services in these rural communities in close collaboration with their hospital partners. HCPF, through the Hospital Transformation Program (HTP), is providing funding to rural hospitals to establish or augment service lines, such as funding shared clinical resources for behavioral health or substance use disorder services. The HTP is further incentivizing all hospitals to collaborate with Federally Qualified Health Centers (FQHCs) and other community providers on activities

like discharge processes so there is connection to post-acute care, behavioral health and other care needs in the community.

BEHAVIORAL HEALTH

Will the contractor [who is mapping out of all the state behavioral health stakeholders] meet with local providers, especially rural ones to better understand how these providers can be integrated into the overall behavioral health system?
The vendor, Health Management Associates, does plan to meet with local providers, and we have passed this comment on to them for their consideration.

Behavioral health is most effective when embedded in primary care, yet this is a challenging model to make work in a practice. How can we make it a more economically feasible model?
Colorado was fortunate to receive funding through the State Innovation Model grant which focused on the integration of physical and behavioral health. In addition to the practice integration resources that are available, Health First Colorado also expanded the payment model for behavioral health services provided in a primary care setting for Health First (Colorado's Medicaid Program) members. More information is in this fact sheet: Short-term Behavioral Health Services in the Primary Care Setting.

Children's mental health, particularly preventive care, is different. How will we make that distinction within BHA?
The Behavioral Health Task Force Subcommittee report includes a set of recommendations regarding how the state needs to serve this population, specifically.

The regulatory burden for mental health and substance use disorder (relative to physical health care) is significant. What is the task force doing to create parity here?
In 2019, the state passed a bill to create a new licensing and regulatory scheme for behavioral health providers in Colorado, with the goal of reducing regulatory burden and aligning requirements across substance use, mental health, and crisis service providers. This is a five-year process, being led by the Department of Public Health & Environment. The implementation and advisory committee is leading this effort, also supported by the Behavioral Health Blueprint: Recommendation #3 Address the bifurcation between mental health and substance use disorder; and Recommendation #10 Reduce the administrative burden for providers.

Are you doing work in the LGTBQ areas as well? So important in behavioral health care.
LGBTQ+ Coloradans are a priority population for the marketing campaigns for Colorado Crisis Services and Lift The Label, which intend to connect Coloradans with life-saving resources for substance use and mental health care. The Colorado Department of Human Services has conducted focus groups and individual interviews with LGBTQ+ Coloradans to improve our campaign efforts. The behavioral health reform efforts include work focused on people with lived experience and their family members and having them participate in co-creation and ideation sessions with us. These sessions will include people from the LGBTQ+ community.

We also know that we have to expand the diversity and competency of our workforce so that the LGBTQ+ community can work with behavioral health professionals and peers with whom they can relate. We are dedicated to continuing to reach out to other agencies to assist in our efforts to serve LGBTQ+ Coloradans.

Have there been any movements towards compensating leaders and Subject Matter Experts in the BIPOC community to speak to what is needed for access to Behavioral Health Care in marginalized communities and how to set forth much needed reparations? I am very interested in this movement and would welcome any ideas or initiatives.
Health equity is a value embraced by the Behavioral Health Task Force, as is increasing cultural competency in our workforce. Our work is focused on involving people with lived experience and their family members and having them participate in co-creation and ideation sessions with state officials. These sessions will include people from marginalized populations. We know we need people who are using the system to help us redesign it so that it actually works for them and all Coloradans.
In early 2021, the Office of Behavioral Health (OBH) will be requesting a Documented Quote (DQ) to pay experienced organizations to help build community connections and trust for their behavioral health awareness campaigns Colorado Crisis Services and Lift The Label, and share them as a resource in the Hispanic/Latinx, African American/Black, Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) and disability communities in Colorado.

Why haven't any of the licensed behavioral health entities throughout the state been invited to the table to work collaboratively with the state to achieve these objectives?
The Behavioral Health Blueprint was created in partnership with behavioral health providers, clients and families, state agencies, advocates, and payers. The full report from the task force outlines more about the process and the behavioral health providers that participated in the task force. The goals outlined in the blueprint will absolutely require partnerships and commitment by all of these stakeholders to achieve true reform.

The behavioral health workforce continues to face significant shortages and funding continues to be cut, is there a plan to address these to paramount issues as the substance use, mental health and suicide continues to increase as a partial result of COVID-19?
The Behavioral Health Blueprint is the first step in the strategic plan to improve the behavioral health system. And while there have been marked increases in funding by both the state and Medicaid over the last several years in behavioral health, we recognize the need to continue to invest in a quality behavioral health system. In addition, the Office of Behavioral Health is hoping that new stimulus funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) will assist in any COVID-19 related impacts.

Will the BHA integrate with the innovative co-responder initiatives to respond to mental health crises in the community?
A non-governmental contractor has been engaged to assist with the analysis of all state-funded behavioral health programs as we determine what programs and funding can and should move under the Behavioral Health Administration (BHA). The Colorado Department of

Human Services -- and the contractor in particular -- will be working with state agencies and counties to determine the way to align, coordinate and/or integrate programs to best meet the needs of Coloradans and improve access to services.

Rural behavioral health services come at a much higher cost due to geographical spread and limited workforce yet there is no differential reimbursement to address these challenges. Is it possible to factor this into rates or create rural rates?
Behavioral health rates are set based on the utilization and cost experience of each RAE. Regional factors, such as the rural nature of a region, are taken into account. Critical Access Hospitals (CAHs), which are almost always rural, receive the rural hospital base rate average. This is done because Medicare does not set a base rate for them like they do for non-CAH hospitals. HCPF is addressing this issue through an inpatient hospital base rate reform project.

HB-1206 from last year is increasing the educational requirements for a substance use disorder counselor to a bachelor's degree minimum yet many of the rural communities have less than 20% of attainment for all bachelor degrees, severely limiting the ability to attract individuals to this line of work. Is there a plan to create an alternative to this requirement?
The state intends to comply with state law; HCPF is not aware of any plan to create an alternative requirement at this time.

CDPHE/COVID-19

When can I or my community get vaccinated?
Currently, Colorado is vaccinating eligible Coloradans for Phase 1A and the first section of Phase 1B. These categories include the highest-risk health care workers and individuals, health care workers with less direct contact with COVID-19, first responders, and people age 70 and older. Once Phase 1 is complete, we will begin vaccinating people in Phases 2 and 3. Please refer to the Colorado Department of Public Health & Environment (CDPHE) website on vaccine distribution for more information on timelines and categories. If you are in Phase 1A, 1B.1 or 1B.2 and have not been notified by or received your vaccine through your employer, you can either try contacting a vaccine provider near you or wait for additional providers to come on board.

The majority of phase 1A recipients will receive the vaccine through their employer, local public health agency or their long-term care facility. CDPHE will provide more information about where Phase 2 and Phase 3 recipients can get their vaccines when those phases are activated.

In what phase of vaccine rollout will people with intellectual disabilities receive the vaccine?
Higher risk individuals who are immunocompromised will be vaccinated in Phase 2 of the vaccine rollout. People with intellectual disabilities living in community care settings are currently receiving vaccines as part of Phase 1A.

What can we expect in the future in order to address the disproportionate impact COVID-19 is having on communities of color? How are you addressing equity in the vaccine programs?
HCPF is coordinating efforts with the Colorado Department of Public Health & Environment (CDPHE), the Division of Insurance, the Department of Human Services and other state agencies to ensure that state departments are prioritizing equity in their approach to vaccine distribution. Our team is working closely with regional organizations and providers to offer support and guidance regarding outreach to at-risk communities. HCPF supports CDPHE's communication and outreach efforts to diverse communities that include multilingual print, video and web materials. Efforts are underway to involve trusted messengers in disseminating factual information about the vaccine to address vaccine hesitancy and mistrust among historically marginalized communities.

What is Colorado's position on vaccinating twice as many people with one dose versus giving both doses?
Colorado is currently following FDA guidance regarding dosage of the vaccines. In a Jan. 4 press release, the FDA said that "at this time, suggesting changes to the FDA-authorized dosing or schedules of these vaccines is premature and not rooted solidly in the available evidence. Without appropriate data supporting such changes in administration, we run significant risk of placing public health at risk, undermining the historic vaccination efforts to protect the population from COVID-19."

If someone is in Phase 1B, and the vaccine is not offered in the workplace, how should they access it?
If you are in Phase 1A, 1B.1 or 1B.2, and you have not been notified by or received your vaccine through your employer, you can either try contacting a vaccine provider near you or wait for additional providers to come on board.

What are the plans around vaccinating incarcerated individuals?
The Colorado Department of Corrections is actively vaccinating individuals in accordance with the current Colorado phasing plan based on age and/or other risk factors.

What is the communication dissemination plan around vaccines and letting people know when it is their turn to be vaccinated?
Being informed is the first part of making a plan. Get your information from reliable public health sources such as the Center for Disease Control and Prevention (CDC), Colorado Department of Public Health & Environment, and your local public health agency. When it's your turn to get the vaccine, ask your primary care provider whether they plan to give the vaccine in their office or what they recommend for you based on your personal medical history. You can learn more about COVID-19 and how to make a plan for you and your family at covid19.colorado.gov.

DOI

Due to the volume of questions for the Division of Insurance (DOI), attendees are requested to send their question to Dora_insurance@state.co.us

DRUG IMPORTATION

Personal experience says that the imported drugs from outside the U.S. are typically manufactured at many of the same locations (not in U.S.) as those sold IN the U.S. Do you see this as well?
The FDA has estimated 40% of finished drugs on the market in the U.S. today are made in a foreign countries and about ingredients, the ingredients used to make the finished product, are produced overseas. Colorado's importation program will be using the same FDA approved manufacturers that are used in the current U.S. system today.

What timeframe do you anticipate for Canadian imports?
We estimate that an importation program in Colorado could be operational by mid-2022, at the earliest.

Hasn't Canada told the U.S. that they WILL NOT export drugs? And aren't those solutions still employing a middleman? i.e., the country itself, the importer, the re-packer, whoever it is that makes sure they aren't fake…
The Canadian government released an Interim Order barring the exportation of any prescription drug which would create or exacerbate a drug shortage. HCPF fully supports protecting Canada's drug supply and access to drugs for the Canadian population. has always taken Canadian drug shortages into account when analyzing drugs suitable for importation. Colorado's importation supply chain is being designed to comply with federal importation regulations while also ensuring safety and cost savings.

What is the actual capacity of Canadian sources to meet U.S. demand for prescription drug importation?
It is our understanding that U.S. and Canadian law allows for flexibility among the foreign seller (Canadian wholesaler) to obtain prescription drugs needed for our program. We do not foresee any challenges in meeting the demand but will collaborate with our selected foreign seller to ensure adequate supply for the Colorado program while protecting access to drugs for Canadians.

Does the panel think that the manufacturers rely on U.S. pricing to enable them to offer the lower prices to other countries?
HCPF describes the drivers that influence the high cost of drugs in the U.S. in *Reducing Prescription Drug Costs, 2nd edition*, on pages 18-35. At a high level, the drivers are lack of transparency and pricing practices, anti-competitive practices on the part of the manufacturers, and marketing and lobbying investment. Such activities are unique to the U.S. market and contribute to the disparity between our prices and those in other countries. Colorado's importation program is focused on bringing lower prices to the Colorado market.

Why are the drugs so much more expensive in the USA compared to other countries?

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Do efforts like this (to purchase drugs from other countries) and the potential loss of revenue for our domestic drug manufacturing companies create domestic incentive to decrease drug costs?
Importation is one strong lever in addressing the high costs of prescription drugs, as it puts downward pressure on manufacturers to modify their current practices. This isn't the only solution to our drug pricing challenges, but does provide an opportunity to demonstrate how lower prices can be achieved. HCPF issued a report, ***Reducing Prescription Drug Costs in Colorado Report - 2nd Edition***, which outlines strategies and solutions, including drug importation, to address these challenges.

How much of the exorbitant costs are associated with American made drugs being safer and better quality? Are the counter arguments focused on safety and fraud concerns? If so, how do we effectively address this tact which is holding us stagnant?
The high cost of the drugs in the U.S. has nothing to do with U.S. versions of the drugs being safer. In most cases, the same drugs are available in other countries, including Canada. The FDA has estimated that 40% of finished drugs on the market in the U.S. today are made in a foreign countries and about 80% of active pharmaceutical ingredients (the ingredients used to make the finished product) are produced overseas. Colorado's importation program will be using the same FDA approved manufacturers that are used in the current U.S. system today. The risk of counterfeit drugs entering the U.S. distribution chain would not be greater in an importation program than it is today.

Are the other countries you've mentioned willing to participate? Is the first country you've selected, Canada, willing to participate?
Currently, based on federal statute, we can only import drugs from Canada and Canada has remained our focus. HCPF has had encouraging discussions with the Canadian consulate in Denver and welcomes a continued dialogue with Canada about our program. We anticipate more communication down the road when the federal government approves a Colorado importation program.

PHARMACY QUESTIONS

Why is double prescribing allowed? A hospital visit can result in a new prescription at discharge for the same medication that was prescribed and currently being taken before the hospital visit, causing waste and additional costs.
Transitions of care, especially when patients move in and out of hospitals, can result in duplicate prescribing. The use of an electronic medical record is one solution that can decrease this occurrence. If health care systems do not have an electronic health record

with insight into all of the medications a patient is taking (i.e., if various systems are not communicating with one another and if physicians are not recording the information), then this is the outcome. It is an operational efficiency that comes as technology advances and as certain requirements are placed on providers to record such information.

Can you expand on the most proposed most favored nations pricing rule for Medicare that pegs U.S. pharmaceutical prices to the lowest cost paid by other developed nations? What are the pros/cons?
The impetus behind this rule is to ensure that Medicare pays no more than the lowest price charged in certain identified countries for certain Part B covered drugs and biologicals. Inherently, the pro is that Medicare would be able to set a price ceiling for specific drugs using other identified countries as a proxy to set the limit. The con is that the pharmaceutical industry will claim that it will stifle innovation and reduce access to drugs. For more information, please refer to page 60 of *Reducing Prescription Drug Costs in Colorado, 2nd Edition*.

Will Medicare negotiating capability be as effective as advertised if the federal government is not prepared and willing to walk away from the table (exclude certain drugs from the formulary), especially for specialty drugs that are most expensive but often also highly valued by patients and patient lobbies?
It is too soon to predict the outcome of such negotiations, but it is a step in the right direction to lower drug costs.

TELEHEALTH/TELEMEDICINE

We are struggling to stop insurance companies from marketing their "virtual" primary care services via telehealth. What steps are being taken to protect LOCAL primary care?
HCPF is committed to developing comprehensive telemedicine policy with the goals of improving access to high-quality services, promoting health equity, and shepherding taxpayer resources. Providing a primary care medical home and medical neighborhood where every Health First Colorado member can access in-person care is a key component to achieving those goals. HCPF is currently seeking legislation that will enable it to enact policies that will strengthen the ties among primary care medical homes and virtual providers, benefiting patients and providers alike. HCPF also continues to study utilization and billing data to learn more about how different providers and provider types are adapting to the new normal that includes telemedicine.

I am concerned about telehealth rate changes Kim mentioned. Will providers have to use two separate billing systems that may discourage their use of telehealth services?
Currently, and for the foreseeable future, fee-for-service telemedicine visits will be paid at parity with their in-person visit counterparts. Any rate changes would be preceded by stakeholder engagement. Place of Service coding modifiers are currently used to identify whether the service described by the CPT code was delivered in an in-person or telemedicine modality. This system of modifiers would continue to be used if parity were

rescinded and rates varied by modality. No additional billing systems or workflows would be necessary.

AFFORDABILITY

I am a small medical business with 15 employees, and we don't offer health care right now. Is there a way to offer our employees' health care affordably?
Health care affordability is challenging for many Coloradans, which is why we have built the Affordability Toolkit which links stakeholders to helpful resources for them to address affordability challenges within their own communities.

RURAL HOSPITAL/MEDICAID RATES

As part of the hospital work, is HCPF looking at outpatient facility fees that many hospitals, especially given consolidation, are assessing on their patients' bills?
Yes, HCPF is examining if more services are being rendered in outpatient hospital facilities - and therefore incurring a facility fee - with the acquisition of physician practices by hospital systems.

What can be done to open additional urgent care facilities on the Western Slope, it appears that individuals in the ER could be redirected to an urgent care facility or physician to cut cost.
Through the Hospital Transformation Program, HCPF is incentivizing the conversion of freestanding emergency departments to facilities that will better meet the needs of the communities, such as primary care, urgent care, maternity or behavioral health service centers. HCPF will continue to explore payment reforms to incentivize care in the right place at the right time.

What would be the implications of expanding criteria for designation of rural hospitals as Critical Access Hospitals, which have a reimbursement model from Medicare that is cost-based (e.g., 101% of "allowed" costs) and not as insufficient as standard Medicare rates?

The determination is made at the federal level, but the state has not completed any analysis that examines what implications would be if these criteria were altered.

Is the Vail health community model able to be reproduced in other rural or non-rural communities ?
Absolutely. Vail Health is working through community partnerships and using their community benefit dollars to expand their local behavioral health capacity.

Medicaid reimbursement rates for some providers in Colorado are inadequately low (below cost) and result in cost shifting by providers.
HCPF has undertaken extensive hospital cost analysis to examine the topic of hospital cost-shifting. In January 2020, HCPF published the *Colorado Cost Shift Analysis Report*. This report thoroughly debunks the concept that Medicaid and Medicare underpayments are to blame for rising hospital commercial prices while introducing Colorado hospital opportunities

to better address their prices, profits and costs to the benefit of Colorado families, employers and the state.

Hospitals' commercial prices are not driven by the cost shift, but by the strategic decisions made by hospitals, or as some might call it, "price discrimination." In his paper titled *How Much Do Hospitals Cost Shift? A Review of the Evidence*, economist Austin B. Frakt distinguishes cost shifting from price discrimination. As explained in the paper, the practice of hospitals charging more to commercially insured patients is referred to as "price discrimination," while hospitals charging more to these patients **specifically to cover shortfalls from public programs** is referred to as the cost shift. For hospitals with a high degree of negotiating leverage, such as those with a large market share or those that have purchased local physician groups enabling them to dominate care delivery in a community, the underpayments by public programs likely have little impact on the prices charged to commercial payers. Furthermore, hospitals with low market power and/or a low proportion of commercially insured patients are more likely to address the lower public program payments by managing their costs well.

Can you consider increasing the Medicaid rates (which were decreased 7/20) for Assisted Living with the Stimulus money? Our insurance for liability increased from $10,000 to $25,000 because of COVID-19.
HCPF empathizes with providers and the difficult challenges you all have faced during the pandemic. HCPF was able to advocate and receive authority from the Colorado Joint Budget Committee to implement rate increases for many HCBS benefits during the pandemic. The original increase was from April 1, 2020 - June 30, 2020, and the next increase is from Jan. 1, 2021 -March 31, 2021. While these increases are temporary, HCPF has heard from providers that they have been incredibly helpful in covering their costs of services and ensuring they remain in operation. Any additional long-term rate increases must be appropriated and authorized by the Colorado General Assembly and approved by the Centers for Medicare and Medicaid Services (CMS).

AFFORDABILITY BOARD
With the advent of novel therapies based on precision medicine, costs of the approved therapies are astronomical. Would the proposed State Board manage these costs, or is this an issue of transparency in pricing that needs to be addressed on a federal level?
The issue could be managed on a state and federal level through different facets, such as: the FDA approval process, re-examining orphan drug status criteria, establishing drug affordability boards, creating drug price transparency policy and initiating value-based contracts with drug manufacturers. The *Prescription Drug Pipeline Report* on pages 110-114 in the *Reducing Prescription Drug Costs in Colorado, 2nd Edition* expands on this.

You cite Maryland's Drug Affordability Board as a model for something that Colorado can do to lower drug costs. However, the Maryland Governor vetoed the bill funding the board. In 2020, the board operated with a $750k loan from another state agency that

they must repay within 3 years. Given Maryland's challenges, why is Colorado still considering this option?
The Maryland legislature last week overrode Gov. Larry Hogan's veto of funding for the nation's first state board created to make drugs affordable. Maryland lawmakers passed the funding bill with a veto-proof majority last spring, but Hogan vetoed the bill after the legislature adjourned, so the override had to wait until the legislature reconvened.

VALUE-BASED PAYMENTS

We all want transparency, quality, lower cost, and reasonable profit. Is it time for the state to establish a task force on value-based payment models which will address all our objectives? We are at the risk of creating 30 different models. Business community will benefit greatly since providers will be aligned with employers, health plans, patients, and hospitals!
Although there is no official task force, HCPF has started a discussion with the Division of Insurance regarding multi-payer models to look into ways to align value-based payments with other payers in the state.

EVENT QUESTIONS

These ads during intermissions are really good. Where are they being run? On social media?
CDPHE received grant funding to produce and run a number of ads in both English and Spanish to encourage people to "Mask-up!" The ad campaign is running on a number of English and Spanish television outlets into February and an accompanying social media campaign will run through March. There were also a handful of Health First Colorado member profile videos hosted on HCPF's YouTube channel from 2019 & 2020 that are promoted across HCPF's social media channels and are available for stakeholders to share.

Would it be possible to get a list of presenters and their email addresses so I can send follow-up questions after the webinar?
Visit the Policy Summit website to get the panelist names from each session, but you'll need to reach out to their respective organizations to get their email address.

SENATOR BENNET

Sen. Bennet, can you talk about the status of your Medicare X proposal? Will you reintroduce it again during this Congress?
I am glad that the Biden Administration will work to ensure that the Affordable Care Act functions at its full capacity, but we have to do more in fighting for universal health coverage. The Medicare-X Choice Act will build on the ACA, creating a public option, driving down health care costs and drastically increasing coverage. I will be reintroducing the legislation with Senator Kaine from Virginia soon and work with President Biden to sign a public option into law as soon as possible.

Last year Sen. Bennet introduced the Increasing Access to Biosimilars Act, which would address the high cost of prescription drugs for seniors by promoting competition,

increasing access to biosimilar medications, and encouraging physicians to prescribe biosimilars with lower out-of-pocket costs. What is the status of that legislation and does he plan to continue pursuing that effort?
Senator Bennet Response: I think we need to be pursuing all avenues to lower the cost of prescription drugs and increasing access and use of biosimilars is critical. I do plan on working on a bipartisan basis with my colleague, Senator Cornyn of Texas, to introduce and pass the Increasing Access to Biosimilars Act.
Pharmacy Team suggested answer: Per Actions - H.R.6179 - 116th Congress (2019-2020): Increasing Access to Biosimilars Act of 2020 this bill was introduced to the house of representatives on March 10, 2020, and there are no further updates.