HEALTH SYSTEM REFORM

2008 GENERAL SESSION

STATE OF UTAH

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LONG TITLE

General Description:

This bill requires the Department of Health, the Insurance Department, and the Governor's Office of Economic Development to work with the Legislature to develop the state's strategic plan for health system reform.

Highlighted Provisions:

This bill:

- directs the Department of Health to work with the Insurance Department, the Department of Workforce Services, the Governor's Office of Economic Development, and the Legislature to develop a state strategic plan for health system reform;
- requires the Insurance Department to participate in the development of the state's

strategic plan for health system reform;

- ▸ requires the Insurance Department to:
  - work with insurers to develop standards for health insurance applications and compatible electronic systems;
  - facilitate a private sector method of collection of premium payments from multiple sources; and
  - encourage health insurers to develop health insurance products that meet certain criteria;
- ▸ changes the threshold at which an individual qualifies for the state's Comprehensive Health Insurance Pool;
- ▸ changes the eligibility for the individual market so that:
  - if Utah's Premium Partnership for Health Insurance may be used to help purchase an individual policy, an insurer may not deny coverage based on the individual's use of a premium subsidy; and
  - eligibility for Utah's Premium Partnership for Health Insurance is a qualifying event for coverage under an employer plan;
- ▸ requires the Department of Workforce Services to participate in the development of the strategic plan for health system reform;
- ▸ enacts the "Health System Reform Act" which:
  - requires the Governor's Office of Economic Development to serve as the coordinating entity to work with the executive branch agencies, and to report to and assist the Legislature with the state's strategic plan for health system reform; and
  - describes the state's strategic plan for health system reform and the time line for implementing the strategic plan; and
- ▸ establishes the Health System Reform Legislative Task Force to develop and implement the state's strategic plan for health system reform.

Monies Appropriated in this Bill:

This bill appropriates:

- as an ongoing appropriation, $615,000, from the General Fund for fiscal year 2008-09 to the Department of Health to be used to fund health care cost and quality data collection, analysis, and distribution;
- $500,000 from the General Fund for fiscal year 2008-09 only, to the Department of Health to fund the department's implementation of the standards developed for the electronic exchange of clinical health information;
- $32,000 from the General Fund for fiscal years 2008-09 only, to fund the Health System Reform Task Force; and
- $350,000 from the General Fund for fiscal year 2008-09 only, to the Health System Reform Task Force to fund professional and actuarial services for the task force.

Other Special Clauses:

This bill repeals the Health System Reform Task Force on November 30, 2008.

Utah Code Sections Affected:

AMENDS:

31A-30-106, as last amended by Laws of Utah 2004, Chapter 108

31A-30-108, as last amended by Laws of Utah 2004, Chapters 2 and 329

ENACTS:

26-18-12, Utah Code Annotated 1953

31A-2-218, Utah Code Annotated 1953

31A-22-610.6, Utah Code Annotated 1953

31A-22-635, Utah Code Annotated 1953

35A-1-104.5, Utah Code Annotated 1953

63M-1-2401, Utah Code Annotated 1953

63M-1-2402, Utah Code Annotated 1953

63M-1-2403, Utah Code Annotated 1953

63M-1-2404, Utah Code Annotated 1953

63M-1-2405, Utah Code Annotated 1953

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-12** is enacted to read:

26-18-12. Strategic plan for health system reform -- Medicaid program.

The department, including the Division of Health Care Financing within the department, shall:

(1) work with the Governor's Office of Economic Development, the Insurance Department, the Department of Workforce Services, and the Legislature to develop health system reform in accordance with the strategic plan described in Title 63M, Chapter 1, Part 24, Health System Reform Act;

(2) develop and submit amendments and waivers for the state's Medicaid plan as necessary to carry out the provisions of the Health System Reform Act;

(3) seek federal approval of an amendment to Utah's Premium Partnership for Health Insurance that would allow the state's Medicaid program to subsidize the purchase of health insurance by an individual who does not have access to employer sponsored health insurance;

(4) in coordination with the Department of Workforce Services:

(a) establish a Children's Health Insurance Program eligibility policy, consistent with federal requirements and Subsection 26-40-105(1)(d), that prohibits enrollment of a child in the program if the child's parent qualifies for assistance under Utah's Premium Partnership for Health Insurance; and

(b) involve community partners, insurance agents and producers, community based service organizations, and the education community to increase enrollment of eligible employees and individuals in Utah's Premium Partnership for Health Insurance and the Children's Health Insurance Program; and

(5) as funding permits, and in coordination with the department's adoption of standards for the electronic exchange of clinical health data, help the private sector form an alliance of

employers, hospitals and other health care providers, patients, and health insurers to develop and use evidence-based health care quality measures for the purpose of improving health care decision making by health care providers, consumers, and third party payers.

Section 2. Section **31A-2-218** is enacted to read:

31A-2-218. Strategic plan for health system reform.

The commissioner and the department shall:

(1) work with the Governor's Office of Economic Development, the Department of Health, the Department of Workforce Services, and the Legislature to develop health system reform in accordance with the strategic plan described in Title 63M, Chapter 1, Part 24, Health System Reform Act;

(2) work with health insurers in accordance with Section 31A-22-635 to develop standards for health insurance applications and compatible electronic systems;

(3) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others by educating employers and insurers about collection services available through private vendors, including financial institutions;

(4) encourage health insurers to develop products that:

(a) encourage health care providers to follow best practice protocols;

(b) incorporate other health care quality improvement mechanisms; and

(c) incorporate rewards and incentives for healthy lifestyles and behaviors as permitted by the Health Insurance Portability and Accountability Act;

(5) involve the Office of Consumer Health Assistance created in Section 31A-2-216, as necessary, to accomplish the requirements of this section; and

(6) in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, make rules, as necessary, to implement Subsections (2), (3), and (4).

Section 3. Section **31A-22-610.6** is enacted to read:

31A-22-610.6. Special enrollment for individuals receiving premium assistance.

(1) As used in this section:

(a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

(b) "Qualified beneficiary" means an individual who is approved to receive premium assistance.

(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:

(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or

(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.

(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.

(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.

(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.

(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.

(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:

(a) is allowed under the Health Insurance Portability and Accountability Act of 1996,

Pub. L. 104-191, 110 Stat. 1936; and

(b) is not longer than 12 months.

Section 4. Section **31A-22-635** is enacted to read:

31A-22-635. Development of uniform health insurance applications.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) Beginning July 1, 2009, all insurers offering health insurance shall use a uniform application form.

(3) The uniform application form shall be adopted and approved by the commissioner in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act. The commissioner shall consult with the health insurance industry when adopting the uniform application form.

(4) (a) Beginning July 1, 2010, all insurers shall offer compatible systems of electronic submission of application forms, approved by the commissioner in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act. The systems approved by the commissioner may include monitoring and disseminating information concerning eligibility and coverage of individuals.

(b) The commissioner shall regulate any fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Section 5. Section **31A-30-106** is amended to read:

31A-30-106. Premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans under this chapter are subject to the provisions of this Subsection (1).

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates

that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(ii) A covered carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d) (i) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

(f) (i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical groups that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(iii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use [~~such~~] a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(h) The covered carrier may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) industry;

(iv) geographic area;

(v) family composition; and

(vi) group size.

(i) (i) The commissioner [~~may~~] shall establish rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by covered carriers are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)(i)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by covered carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by covered carriers;

(C) implement the individual enrollment cap under Section 31A-30-110, including

specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

(j) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding [~~200%~~] 325% of that expected for a standard insurable individual with the same case characteristics.

(k) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard:

(i) to case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) Each covered carrier shall maintain at the covered carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the covered carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each covered carrier shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the covered carrier is in compliance with this chapter; and

(B) the rating methods of the covered carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the covered carrier at the covered carrier's principal place of business.

(c) A covered carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records Access and Management Act.

Section 6. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962, Sec. 2701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant:

(i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

(ii) Subsection (3).

(2) (a) Small employer carriers shall offer to accept all eligible employees and their

dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i) (A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

[~~(ii) the Medicaid program established under Title XIX of the Social Security Act;~~]

[~~(iii)~~] (ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

[~~(iv)~~] (iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111 (5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111 (5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the

state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b).

(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the Utah Insurance Department.

(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an

employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (7)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.

Section 7. Section **35A-1-104.5** is enacted to read:

35A-1-104.5. Strategic plan for health system reform.

The department shall work with the Department of Health, the Insurance Department, the Governor's Office of Economic Development, and the Legislature to develop the health system reform in accordance with Title 63M, Chapter 1, Part 24, Health System Reform Act.

Section 8. Section **63M-1-2401** is enacted to read:

Part 24. Health System Reform Act

63M-1-2401. Title.

This part is known as the "Health System Reform Act."

Section 9. Section **63M-1-2402** is enacted to read:

63M-1-2402. Definitions.

As used in this part, "office" means the Office of Consumer Health Services created in Section 63M-1-2404.

Section 10. Section **63M-1-2403** is enacted to read:

63M-1-2403. Duties related to health system reform.

The Governor's Office of Economic Development shall coordinate the efforts of the Office of Consumer Health Services, the Department of Health, the Insurance Department, and

the Department of Workforce Services to assist the Legislature with developing the state's strategic plan for health system reform described in Section 63M-1-2405.

Section 11. Section **63M-1-2404** is enacted to read:

63M-1-2404. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Section 31A-22-635, create an Internet portal that is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures;

(b) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others by educating employers and insurers about collection services available through private vendors, including financial institutions; and

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars.

(3) The office may not:

(a) regulate health insurers, health insurance plans, or health insurance producers;

(b) adopt administrative rules; or

(c) act as an appeals entity for resolving disputes between a health insurer and an insured.

Section 12. Section **63M-1-2405** is enacted to read:

63M-1-2405. Strategic plan for health system reform.

The state's strategic plan for health system reform shall include consideration of the following:

(1) legislation necessary to allow a health insurer in the state to offer one or more health benefit plans that:

(a) allow an individual to purchase a policy for individual or family coverage, with or without employer contributions, and keep the policy even if the individual changes employment;

(b) incorporate rating practices and issue practices that will sustain a viable insurance market and provide affordable health insurance products for the most purchasers;

(c) are based on minimum required coverages that result in a lower premium than most current health insurance products;

(d) include coverage for immunizations, screenings, and other preventive health services;

(e) encourage cost-effective use of health care systems;

(f) minimize risk-skimming insurance benefit designs;

(g) maximize the use of federal and state income tax policies to allow for payment of health insurance products with tax-exempt funds;

(h) may include other innovative provisions that may lower the costs of health insurance products;

(i) may incorporate innovative consumer-driven provisions, including:

(i) an exemption from selected state health insurance laws and regulations;

(ii) a range of benefit and cost sharing provisions tailored to the health status, financial capacity, and preferences of individual consumers; and

(iii) varying the amount of cost sharing for a service based on where the service falls along a continuum of care ranging from preventive care to purely elective care; and

(j) encourage employers to allow their employees greater control of the employee's health care benefits by providing tax-exempt defined contributions for the purchase of health insurance by either the employer or the employee;

(2) current rating and issue practices by health insurers and changes that may be necessary to achieve the goals of Subsection (1)(b);

(3) methods to decrease cost shifting from the uninsured and under-insured to the

insured, health care providers and taxpayers, including:

(a) eligibility and benefit levels for entitlement programs;

(b) reimbursement rates for entitlement programs; and

(c) the Utah Premium Partnership for Health Insurance Program and the Children's Health Insurance Program's enrollment and benefit policies, and whether those policies provide appropriate and effective coverage for children;

(4) providing public employees an option that gives them greater control of their health care benefits through a system of defined contributions for insurance policies;

(5) giving public employees access to an option that provides individually selected and owned policies;

(6) encouraging the use of health care quality measures and the adoption of best practice protocols by health care providers for the benefit of consumers, health care providers, and third party payers;

(7) providing some protection from liability for health care providers who follow best practice protocols;

(8) promoting personal responsibility through:

(a) obtaining health insurance;

(b) achieving self reliance;

(c) making healthy choices; and

(d) encouraging healthy behaviors and lifestyles to the full extent allowed by the Health Insurance Portability and Accountability Act;

(9) studying the costs and benefits associated with:

(a) different forms of mandates for individual responsibility; and

(b) potential enforcement mechanisms for individual responsibility;

(10) (a) increasing the number of affordable health insurance policies available to a person responsible for obtaining health insurance under Subsection (8)(a) by creating a system of subsidies and Medicaid waivers that bring more people into the private insurance market; and

(b) funding subsidies to support bringing more people into the private insurance market,

which may include:

(i) imposing assessments on:

(A) health care facilities;

(B) health care providers;

(C) health care services; and

(D) health insurance products; or

(ii) relying on other funding sources;

(11) investigating and applying for Medicaid waivers that will promote the use of private sector health insurance;

(12) identifying federal barriers to state health system reform and seeking collaborative solutions to those barriers;

(13) maximizing the use of pre-tax dollars for health insurance premium payments;

(14) requiring employers in the state to adopt mechanisms that allow an employee to use tax-exempt earnings, other than pre-tax contributions by the employer, to purchase a health insurance product;

(15) extending a preference under the state procurement code for bidders who offer goods or services to the state if the bidder provides health insurance benefits or a defined contribution for health insurance to the bidder's employees; and

(16) requiring insurers to accept premium payments from multiple sources, including state-funded subsidies.

Section 13. **Health System Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

(1) There is created the Health System Reform Task Force consisting of the following 11 members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom may be from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom may be from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a cochair of the task force.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

(3) In conducting its business, the task force shall comply with the rules of legislative interim committees.

(4) Salaries and expenses of the members of the task force shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override Sessions.

(5) The Office of Legislative Research and General Counsel and the Governor's Office of Economic Development shall provide staff support to the task force.

Section 14. **Duties -- Interim report.**

(1) The task force shall review and make recommendations on the state's development and implementation of the strategic plan for health system reform described in Section 63M-1-2405.

(2) A report, including any proposed legislation, shall be presented to the Business and Labor Interim Committee before November 30, 2008.

Section 15. **Appropriation.**

There is appropriated:

(1) as an ongoing appropriation, $615,000, from the General Fund for fiscal year 2008-09 to the Department of Health to be used to fund health care cost and quality data collection, analysis, and distribution;

(2) $500,000 from the General Fund for fiscal year 2008-09 only, to the Department of Health to fund the Department of Health's implementation of the standards developed for the electronic exchange of clinical health information;

(3) $12,000 from the General Fund for fiscal years 2008-09 only, to the Senate to pay for the compensation and expenses of senators on the Health System Reform Task Force;

(4) $20,000 from the General Fund for fiscal years 2008-09 only, to the House of Representatives to pay for the compensation and expenses of representatives on the Health System Reform Task Force; and

(5) $350,000 from the General Fund for fiscal year 2008-09 only, to the Office of Legislative Research and General Counsel to fund professional and actuarial services for the Health System Reform Task Force.

Section 16. **Repeal date.**

The Health System Reform Task Force created in Section 13 of this bill is repealed November 30, 2008.