

**MINUTES OF THE
PRIVATELY OWNED HEALTH CARE ORGANIZATION TASK FORCE**

Monday, October 16, 2006 – 1:30 p.m. – Room W135 House Building

Members Present:

Sen. Michael G. Waddoups, Senate Chair
Rep. David Clark, House Chair
Sen. Gene Davis
Sen. John W. "Bill" Hickman
Sen. Peter C. Knudson
Sen. Mark B. Madsen
Sen. Ed Mayne
Rep. Jackie Biskupski
Rep. Stephen D. Clark
Rep. Brad L. Dee
Rep. James A. Dunnigan
Rep. Rebecca D. Lockhart

Members Absent:

Speaker Greg J. Curtis
Rep. Patricia W. Jones
Rep. Bradley G. Last

Staff Present:

Constance C. Steffen, Policy Analyst
Allison Morgan, Policy Analyst
Catherine J. Dupont, Associate General Counsel
Brooke Ollerton, Legislative Secretary

Note: A list of others present, a copy of related materials, and an audio recording of the meeting can be found at www.le.utah.gov.

1. Task Force Business

Chair Clark called the meeting to order at 1:46 p.m. and announced that Speaker Curtis, Rep. Jones, and Rep. Last were excused from the meeting.

MOTION: Rep. Dee moved to approve the minutes of the September 21, 2006 meeting. The motion passed unanimously with Sen. Hickman and Sen. Madsen absent for the vote.

2. Tax Exemptions for Health Care Organizations that Provide Charity Care

Chair Waddoups reported that staff is researching the availability of more recent tax data, specifically property and sales taxes, and the estimated costs of extending certain tax exemptions to other entities. He said he would be interested in bringing the information back to the Task Force to review.

Rep. S. Clark asked Chair Waddoups how additional tax revenues may be used. Chair Waddoups replied that revenues could possibly be used to pay for services for the uninsured or other charity care.

Sen. Hickman cautioned that if this plan were to be implemented, the Task Force would not only need to consider revenues, but also be aware of the costs of such a program.

3. Access to Health Care Providers

Sen. Knudson reviewed the history of Utah's Rural Access to Health Care Provider Law. He explained the original intent of the bill and the extent to which it had been accomplished. He asked for the viewpoint of the hospitals, physicians, and insurance community on its effectiveness.

Ms. Dupont referred to a handout in the mailing packet, "Overview of Utah's Access to Rural Health Care Provider Law," explaining how the law is implemented. She explained that recently released

Department of Insurance rules have made it easier to determine which hospitals and clinics qualify under the statute. She said that HMOs are also required to notify enrollees when they live in an area that may make them eligible under the rural access law. She commented that some people have raised issues not covered in the law such as admitting privileges and balance billing, but she did not know if these other issues were originally intended to be in the law.

Mr. David Gessel, Vice President for Government Relations, Utah Hospitals and Health Systems Association, acknowledged that although the rural access law was complex and some people may want to see changes, the hospitals in his organization feel that the law is working well and would encourage no changes. He answered questions from the Task Force including further explanation of what defines a rural hospital.

Ms. Dupont clarified that when determining whether the rural access law applies one must consider whether the hospital is an independent hospital, whether the enrollee can bypass a rural hospital and be covered at another, and whether the enrollee lives within 30 paved road miles of the independent hospital. She pointed out that there are enough exceptions in the law that it is doubtful the law could be characterized as an "any willing provider" law.

Ms. Michelle McOmber, representing the Utah Medical Association, said that in addition to its original purpose, the rural access law also gives patients access to more providers in a rural area. It is important, she said, that there are enough providers in rural areas. She commented that there have been some problems in rural areas with physicians who have been promised privileges when they move into a rural area and do not ultimately receive those privileges, but overall the law has been useful.

Mr. Kelly Atkinson, Executive Director, UHIA (Utah Health Insurance Association), said that when the legislation was drafted, many rural providers did not have contracts with insurance carriers. Now most community hospitals have relationships with major carriers. He asked the Task Force to determine whether there is a continued need for the rural access law and stated that UHIA would prefer to repeal the law or secondly, to leave it as is. If any changes were made, he would suggest requiring contractual relationships between hospitals and insurers and limiting the hospitals' ability to balance bill enrollees of the insurance companies.

Mr. Frank Kyle, representing UHIA, added that most HMO carriers do try to contract because it is easier for them to conduct business with a contract in place, and that more contracts are in place now than in the past.

4. Other Items / Adjourn

The Task Force discussed whether an additional meeting would be held. Chair Clark announced that the chairs would schedule the meeting and inform the Task Force.

Rep. S. Clark suggested that the Task Force hold a meeting to summarize its work and provide a report.

Chair Clark stated that the statute requires a final written report to two interim committees.

MOTION: Sen. Knudson moved to adjourn. The motion passed unanimously.

Chair Clark adjourned the meeting at 2:49 p.m.