House BILL NO. 548

INTRODUCED BY Carey

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE MONTANA HEALTH SECURITY SYSTEM; CREATING AN INTEGRATED PAYMENT MECHANISM FOR HEALTH CARE; SETTING ELIGIBILITY REQUIREMENTS; AUTHORIZING THE MONTANA HEALTH CARE AUTHORITY TO DEFINE THE BENEFITS; OUTLINING THE HEALTH CARE AUTHORITY'S DUTIES AND POWERS; PROVIDING FOR TRANSFER OF STATE PROGRAMS UPON STUDY BY THE HEALTH CARE AUTHORITY; PROVIDING FOR PUBLIC HEARINGS, MONITORING, AND EVALUATION; PROVIDING FOR EXEMPT EMPLOYERS AND EMPLOYEES; PROVIDING FOR COLLECTION FROM COLLATERAL SOURCES; PROVIDING FOR BUDGETS AND EXPENDITURE LIMITS FOR THE HEALTH SECURITY SYSTEM; PROVIDING FOR CHOICES IN FORMS OF PROVIDER REIMBURSEMENT AND PAYMENT MECHANISMS; PROVIDING FOR PROVIDER REPRESENTATION IN NEGOTIATIONS; ALLOWING INTEGRATED DELIVERY SYSTEMS; PROVIDING FOR CAPITAL EXPENDITURES; PROVIDING FOR COST CONTROL MEASURES; PROVIDING ENFORCEMENT MECHANISMS; PROVIDING FOR A PHASEIN OF THE HEALTH SECURITY SYSTEM; PROVIDING FOR HEARINGS AND JUDICIAL REVIEW; PROVIDING FOR PRACTICE OUTSIDE OF THE HEALTH SECURITY SYSTEM; PROVIDING FOR OPEN PARTICIPATION; PROVIDING FOR COORDINATION WITH OTHER LAWS; PROVIDING FOR COMPLIANCE WITH FEDERAL LEGISLATION; PROVIDING FOR THE HEALTH CARE AUTHORITY TO APPLY FOR NECESSARY FEDERAL WAIVERS; CREATING A HEALTH SECURITY FUND AND RESERVE ACCOUNT; PROVIDING FOR APPROPRIATIONS BY THE LEGISLATURE; PROVIDING FUNDING PROVISIONS; CREATING A HEALTH SECURITY FUND PERSONAL INCOME TAX AND CREDIT; CREATING AN EMPLOYER HEALTH SECURITY SYSTEM PAYROLL TAX, PHASEIN, OPTION, AND CREDIT; CREATING A CORPORATE HEALTH SECURITY FUND INCOME TAX; CREATING A HEALTH SECURITY FUND CIGARETTE TAX; CREATING A HEALTH SECURITY FUND TOBACCO PRODUCTS TAX; CREATING A HEALTH SECURITY FUND GAMBLING MACHINE LICENSING TAX; CREATING A HEALTH SECURITY FUND ACCOMMODATIONS TAX; PROVIDING FOR TWO-THIRDS VOTE FOR CERTAIN FUTURE LEGISLATIVE AMENDMENTS; AND AMENDING SECTIONS 15-1-501 AND 17-5-408, MCA."

STATEMENT OF INTENT

A statement of intent is required for this bill in order to provide the Montana health care authority

rulemaking authority to adopt standards and criteria by rule for primary care; medical specialists; prescription drugs; allocation of operating funds; provider and facility reimbursement; termination of participation; urban and rural facilities; primary, secondary, and tertiary care; public health; financial criteria and disclosure by providers for interest in facilities; and utilization.

It is the intent of the legislature that the rules:

(1) address the process of establishing and maintaining a statewide health security system;

(2) develop an integrated payment mechanism for health care;

(3) provide coverage for all eligible persons in Montana;

(4) establish a comprehensive benefits package to which all eligible persons have access;

(5) establish a process for cost containment; and

(6) provide an equitable and broad-based funding system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Short title.** [Sections 1 through 82, 101, 104, and 105] may be known as the "Montana Health Security Act".

NEW SECTION. **Section 2. Findings.** The people of the state of Montana find and declare as follows:

(1) Rapidly rising health care spending has outstripped the growth in Montana's economy and has placed a growing burden on Montana families and state government.

(2) An estimated 100,000 or more Montanans lack any form of health care coverage.

(3) The vast majority of uninsured Montanans have direct or indirect ties to the work force.

(4) Despite this link to the work force, the majority of the uninsured are low-income individuals and families.

(5) Many of the state's uninsured are children and young adults.

(6) A significant number of Montanans are "underinsured".

(7) Because of the significant provider shortages that exist throughout the state, many Montanans do not have reasonable access to health care services.

(8) A lack of consistent and timely data about the costs, use, and quality of Montana's health care

system means that providers and consumers alike cannot obtain relevant and up-to-date information regarding the efficiency and effectiveness of services.

NEW SECTION. **Section 3. Guiding principles -- policy -- goals -- objectives.** (1) The policy of the state is to ensure that all residents have access to quality health care at costs that are affordable.

(2) The overriding goal of the state is to improve the health status of its population. To achieve this goal, the state should develop and implement a multifaceted strategy that includes health care system reform, efforts to improve the population's health-related behaviors, and other public health oriented activities. The reform of the health care system is the development of a single payer system to finance health care services predominantly through public funds to provide a uniform set of benefits administered by a single entity managed by the state government.

(3) The objectives of a reformed health care system are to:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income;

(c) avoid unnecessary duplication in the development of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(e) promote the rational allocation of health resources in the state;

(f) facilitate universal access to preventive, primary, and other medically necessary health care; and

(g) educate consumers about the proper use of the health care system and about the importance of individuals assuming greater responsibility for their own health status by improving their health-related behavior.

(4) Additional objectives of a reformed system are to:

(a) operate as efficiently and effectively as possible, with the administrative aspects of the system made as simple and "user friendly" as possible; and

(b) provide accurate and accessible information that will enable consumers and providers to make more informed decisions and that will provide better measures of the performance of the health care delivery system, including patient outcomes.

(5) In reforming the health care system to achieve these objectives, the state shall ensure that any

negative impacts of its reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

NEW SECTION. **Section 4. Definitions.** As used in [sections 1 through 82, 101, 104, and 105], unless the context requires otherwise, the following definitions apply:

(1) "Authority" means the Montana health care authority, as provided in 50-4-201, established to make expert recommendations on all aspects of health care policy.

(2) "Base year" means the 12 months prior to [the effective date of this act].

(3) "Capitation" means allocation of health security system funds to a professional provider or integrated professional provider network based on the number of individuals whose health care must be covered, with respect to all benefits available under the health security system, for the calendar year, or part of a calendar year, by that professional provider or professional provider network.

(4) "Emergency care" means health care services required for alleviation of severe pain or distress or for immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, could lead to disability or death.

(5) "Employee" means a resident of Montana who works for an employer, is listed on the employer's payroll records, and is under the employer's control.

(6) (a) "Employer" means any person, partnership, corporation, association, joint venture, or public or private entity employing for wages, salary, or other compensation one or more employees at any one time to work in this state.

(b) Employer does not include self-employed persons with respect to earnings from self-employment.

(7) "Health care facility" means a facility licensed pursuant to Title 50, chapter 5.

(8) "Health security system" means the program of comprehensive health services administered by the authority as set out in [sections 1 through 82, 101, 104, and 105] and all policies and directives of the authority.

(9) "Medical care" means all health care items and services, except for items and services not reasonable and necessary for the diagnosis, treatment, or prevention of illness or injury or to improve the functioning of a malformed or injured body member, according to guidelines established by the authority.

(10) "Medical indication" means the set of medical conditions for which there is evidence that a

particular service improves the overall health outcome of patients receiving that service.

(11) "Medically appropriate" means all health care services and procedures chosen by the patient's professional provider subject to the guidelines established by the authority.

(12) "Mental health care" means health care services provided for the prevention, diagnosis, or treatment of one or more mental disorders, including substance dependence and abuse and diseases of the brain.

(13) "Mode of reimbursement" means the way in which a professional provider is paid, including but not limited to any of the following:

(a) a fee for each service provided;

(b) capitation;

(c) salary.

(14) "Primary care" means comprehensive, longitudinal, individual clinical prevention and treatment services provided by a professional provider acting within the scope of the professional provider's practice and subject to standards and criteria adopted by rule.

(15) "Primary care provider" means a professional provider delivering primary care.

(16) "Professional provider" means an individual licensed to provide health care services pursuant to Title 37, chapters 3 through 8, 10 through 17, and 20 through 29.

(17) "Provider" means a professional provider or health care facility.

(18) "Resident" means a resident of Montana as defined in 1-1-215 or as otherwise defined by statute.

(19) "Secondary care" means both of the following:

(a) outpatient health care services other than those that constitute primary care; and

(b) inpatient health care services other than those that constitute tertiary care.

(20) "Specialist" means those professional providers who are certified by a specialty board or eligible for certification, who currently provide specialized health care services in Montana, or who provide specialized health care services and accept referrals from primary care providers, case managers, and other specialists, subject to standards and criteria adopted by rule.

(21) "State gross domestic product" means the sum total of the value of all goods sold and services provided in Montana for any year as determined by the U.S. department of commerce.

(22) "System" means the health security system established by [sections 1 through 82, 101, 104,

and 105].

(23) "System budget" means the amount of money projected to be spent in the state on health care in any year under the health security system pursuant to [sections 16, 32 through 51, 76, and 77].

(24) "Tertiary care" means specialized diagnostic and treatment services designated by the authority.

NEW SECTION. **Section 5. Eligibility.** All Montanans who meet residency requirements as defined in 1-1-215 and otherwise defined by the statute are eligible for covered benefits specified in [sections 9 through 14].

NEW SECTION. **Section 6. Eligibility cards.** (1) The authority shall certify the eligibility of each individual and shall provide each eligible individual with a card with an identifying number listing any limitations of the services for which the individual is eligible. The card must be in the form determined by the authority consistent with federal law.

(2) (a) In the case of individuals under 18 years of age, the authority shall issue the card to a person having legal custody of the minor. More than one minor may be listed on a single card.

(b) An eligible minor who is legally capable of giving consent to health care may apply to the authority for a separate card. The card must be limited to the types of care for which the minor may lawfully consent.

(3) (a) Within 30 days of receipt of a completed application, the authority shall issue an eligibility card or provide a written explanation for its denial or for any restrictions placed on the eligibility card.

(b) If good cause exists to believe that the applicant may not meet the eligibility requirements, the authority may extend the period under subsection (3)(a) up to an additional 30 days to permit further investigation.

(c) When necessary to avoid an interruption in care, the authority may issue a temporary eligibility card.

NEW SECTION. **Section 7. Presumptive eligibility.** (1) Upon arrival at a health care facility, if a person is unconscious, comatose, or otherwise unable because of the person's physical or mental condition to document eligibility or to act in the person's own behalf or if the person is a minor, the person is

presumed to be eligible and the health care facility shall provide care as if the person were eligible.

(2) An individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds pursuant to any provision of Title 53, chapter 21, that provides for involuntary commitment is presumed eligible.

NEW SECTION. **Section 8. County obligations.** The Montana Health Security Act does not relieve the counties of their obligation under Title 53, chapter 2.

NEW SECTION. **Section 9. General benefits.** (1) An eligible individual may choose to receive service from any willing professional provider participating in the health security system.

(2) An eligible individual may not be required to meet a deductible or copayment as a condition for receiving health care services by any health care facility or professional provider reimbursed by the health security system except as follows:

(a) as authorized by the authority under provisions for implementing the phasein of the health security system, as provided in [sections 64 through 67].

(b) for cost control purposes as specified in [sections 49 and 50].

NEW SECTION. **Section 10. Medical benefits.** (1) The authority shall, by January 1, 1996, adopt rules to implement the medical benefit package provided in the Montana health care authority universal access plan.

(2) The authority shall consider providing benefits for outreach, education, prevention, and screening services, including but not limited to:

(a) children's preventive care, well-child care, immunizations, screening, outreach, and education; and

(b) adult preventive care including mammograms, pap smears, and other screening, outreach, and educational services.

(3) The authority shall consider including long-term care benefits in the health security system after completion of the long-term care study as provided in 50-4-310. The recommendations to the public and to the legislature must contain recommendations regarding long-term care benefits.

NEW SECTION. **Section 11. Expansion of covered benefits.** (1) The authority may expand benefits when expansion meets the intent of the health security system and there are sufficient funds to cover the expansion.

(2) Coverage for any service or benefit not previously covered by the health security system may be instituted without expansion of benefits if the authority determines it is of equivalent therapeutic value or is a less costly treatment alternative to a listed service and if the service or benefit is provided by a professional provider acting within the scope of the professional provider's practice.

NEW SECTION. **Section 12. Exclusion of benefits.** (1) Services determined to have no medical indication by the authority must be excluded from coverage under the health security system.

(2) Elective services may be restricted or excluded from coverage under the cost containment provisions of [section 50].

NEW SECTION. **Section 13. Coverage for Montanans while out of state.** (1) The health security system shall cover all eligible Montana residents traveling out of the state for up to 90 days in each 12-month period.

(2) Coverage for emergency care must be at prevailing local rates.

(3) Coverage for nonemergency care must be according to rates and conditions established by the authority. The authority may require transport back to Montana for further treatment when the patient is medically stable.

(4) The authority may make arrangements for reciprocal coverage with other states or countries, provided that the programs provided by the other states or countries are comparable to those available in Montana regarding coverage, cost, and quality.

NEW SECTION. **Section 14. Emergency benefits.** Emergency care and health care services necessary to safeguard the health of the population must be readily available through the health security system to all individuals.

NEW SECTION. **Section 15. Authority health security system powers and duties.** (1) The authority's powers include all powers necessary and proper to implement [sections 1 through 82, 101,

104, and 105] and to promote its underlying aims and purposes. These broad powers include but are not limited to the power to set rates and adopt rules on all matters relating to the implementation of [sections 1 through 82, 101, 104, and 105].

(2) The authority shall establish and maintain a system of universal access to medical care for all Montanans including the following:

(a) implement statutory eligibility standards;

(b) adopt annually a benefits package for consumers;

(c) act directly or through one or more contractors as the single payor for all claims for services provided under [sections 32 through 38];

(d) develop and implement separate formulas for determining budgets pursuant to [sections 32 through 38];

(e) review the formulas described in subsection (2)(d) annually for appropriateness and sufficiency of rates, fees, and prices;

(f) provide for timely payments to professional providers and health care facilities through a structure that is efficient to administer and that eliminates unnecessary administrative costs. The cost of administration of the health security system may not exceed the limits set in [sections 32 through 38].

(g) implement, to the extent permitted by federal law, standardized claims and reporting methods;

(h) establish an enrollment system that will ensure that all eligible Montanans, including those who travel frequently, those who cannot read, and those who do not speak English, are aware of their right to health care and are formally enrolled;

(i) determine the number and precise county-by-county composition of the system regions, based on criteria of common economic and demographic features and geographic contiguity;

(j) bid for prescription drug contracts in order to achieve the lowest possible cost for drugs available under the system;

(k) negotiate for or set, rates, fees, and prices involving any aspect of the health security system and establish procedures relating to rates, fees, and prices;

(l) administer the revenue of the health security system in accordance with [sections 78 through 82];

(m) procure funds (including loans), lease or purchase property, and obtain appropriate liability and other forms of insurance for the health security system and its employees and agents;

(n) establish, appoint, and fund, as part of the administration of the health security system, the regional health care planning boards;

(o) administer all aspects of the health security system that include but are not limited to the following:

(i) establish standards and criteria by rule for allocation of operating funds;

(ii) meet regularly with the regional health care planning boards to review the impact of the health security system and its policies on the regions;

(iii) budget to most equitably meet the health care needs of the population of the state as a whole and the population within each region pursuant to the specific purposes that have been established;

(iv) achieve the best pharmaceutical drug prices for the health security system; and

(p) gather and analyze data necessary for the efficient and equitable functioning of the health security system pursuant to 50-4-502;

(3) In addition to all other powers conferred under [sections 1 through 82, 101, 104, and 105], the authority may:

(a) employ appropriate staff as necessary to implement [sections 1 through 82, 101, 104, and 105];

(b) delegate to appointed staff any aspect of the health security system that is the responsibility of the authority. Individuals employed by the authority or by any department or state agency that is made a part of the health security system shall perform their duties as the authority assigns them.

(c) employ and direct attorneys on staff or as outside counsel in the defense or implementation of any provision of [sections 1 through 82, 101, 104, and 105];

(d) sue and be sued to enforce any provision of [sections 1 through 82, 101, 104, and 105];

(e) seek, at the authority's discretion, legal advice or counsel from the attorney general;

(f) incur travel expenses as are necessary for the performance of the authority's duties;

(g) issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the administration of the health security system;

(h) adopt rules for procedures and standards for competitive bidding that govern the contracts authorized by this section. The provisions of Title 18 do not apply to the competitive bidding requirements; and

(i) ensure that all existing statutes regarding confidentiality of medical records apply to the health

security system. A policy, directive, or study by the authority may not be taken that compromises confidentiality of medical records as established by law.

NEW SECTION. **Section 16. Transfer of state facilities -- programs.** (1) [Sections 1 through 82, 101, 104, and 105] to not prevent the legislature from transferring to the health security system programs for health care, including mental health care for patients in state hospitals and other health care facilities owned by the state and facilities located in state prisons.

(2) Programs for individual clinical prevention and treatment administered by the departments of corrections and human services, social and rehabilitation services, and health and environmental sciences and any other state or county entity that provides individual clinical prevention and treatment services must be administered by the authority to the extent that those programs are transferred to the health security system.

(3) Local health departments shall continue to provide clinical services when needed to reach special or underserved populations and to fulfill the counties' responsibility to provide health care services pursuant to Title 53, chapter 2. However, to the greatest extent possible, those facilities must be funded for these services from the health security fund under the same overall operating expense budgets according to formulas applied to all health care facilities.

(4) Those programs concerned with population-based public health activities and core public health functions remain the responsibility of the department of health and environmental sciences.

(5) The legislature shall take steps to consolidate the administration of residual programs in those state departments with functions that have been significantly appropriated to the health security system in order to maintain administrative efficiency and to effectively carry out the goals for which any residual programs were established.

(6) The authority shall prepare a plan to present to the legislature that provides for the orderly transition of programs from other state agencies for incorporation into the health security system. The plan must include provisions for:

(a) statewide planning and other programs of the department of health and environmental sciences;

(b) institutional services provided by the department of corrections and human services;

(c) medical assistance and medicaid from the department of social and rehabilitation services in the event of the receipt of federal waivers; and

(d) the state employee medical benefit plan administered through the department of administration.

(7) The authority shall address the issue of workers' compensation and make a decision on the eventual incorporation of the medical portion of workers' compensation benefits into the health security system. The authority shall address mechanisms to maintain the important link between medical benefits and indemnity.

NEW SECTION. **Section 17. Prohibition against confiscatory rates.** (1) The authority may not set any rate, fee, or price, that is confiscatory.

(2) A provider, vendor, or other person aggrieved by a rate, fee, or price set by the authority, upon the production of credible evidence that the rate, fee, or price is confiscatory, is entitled to a timely hearing.

(3) This section does not apply to any rate, fee, or price that is negotiated with the authority.

NEW SECTION. **Section 18. Public hearings.** The authority and the regional health care planning boards shall jointly sponsor public hearings, at least yearly in each region, at which testimony must be taken regarding the following:

(1) the authority's proposals for resource allocation, revenue generation, and other substantive policy changes for the coming year; and

(2) the responsiveness of health care facilities in the region to the health care needs of the local communities and populations they serve.

NEW SECTION. **Section 19. Monitoring and evaluation.** (1) The authority shall establish a standard set of indicators and methods to be used to assess the effectiveness of the health security system in implementing and fulfilling the intent and purposes of [sections 1 through 82, 101, 104, and 105]. The indicators and methods should include but are not limited to the current federal center for disease control and prevention's consensus list of population health outcome indicators and indicators of child health, maternal health, safety and cost of births, promptness and appropriateness of treatment for cancer and other diseases, surgical survival and success rates for common procedures, functional status in the elderly, communicable disease rates, monitoring of out-of-pocket expenditures, availability of services including geographic proximity and waiting times, the number and types of staff employed by professional providers, and the number of each category of professional provider giving hands-on care.

(2) As a condition of reimbursement, professional providers and health care facilities must be required to report to the authority a certain amount of clinical data to be used to assist in the health security system's health outcome monitoring effort and for the purposes of improving the effectiveness of practice by professional providers and health care facilities.

(3) Clinical data provided by individual professional providers must be confidential and used only for statistical and systemwide purposes and for improving the quality of care.

(4) The authority shall make the nonconfidential data and analysis generated pursuant to this section available to the regional health care planning boards, state and local health departments, and the public in a timely manner.

(5) The authority shall establish uniform fiscal and medical reporting requirements for all professional providers. Health care facilities and professional providers, including those in integrated delivery systems, shall provide information to the authority about financial relationships with other health care facilities and professional providers. The information must be available for public disclosure in order to ensure that health care facilities and professional providers do not collude to increase prices or evade cost controls.

(6) The data disclosure activities of the health security system may not infringe on the confidentiality of health security system information on individuals and their medical records.

NEW SECTION. **Section 20. Collective bargaining protected.** [Sections 1 through 82, 101, 104, and 105] may not be construed to affect or diminish the benefits that an individual may have under a collective bargaining agreement.

NEW SECTION. **Section 21. Employees covered by health plan subject to preemption.** (1) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that, under federal law, preempts provisions of [sections 1 through 82, 101, 104, and 105] shall first seek benefits under that contract or plan before receiving benefits under the health security system.

(2) Benefits may not be denied under the health security system unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if those benefits are available.

(3) This section may not preclude an employee from receiving benefits under the health security system that are superior to benefits available to the employee under the contract or plan.

(4) [Sections 1 through 82, 101, 104, and 105] are not intended nor may they be construed to discourage recourse to contracts or plans that are protected by federal law.

(5) (a) Any physician or health care provider, including a hospital, may render services pursuant to a contract or plan subject to federal preemption without regard to the limitations on professional provider fees contained in [section 39].

(b) To the extent permitted by federal law, the provider shall first seek payment from the contract or plan before submitting bills to the health security system.

(c) Any fee charged by the provider in excess of the rate set or negotiated by the authority may not serve to increase the amount of funding available to the provider from the health security system in the current or subsequent years.

NEW SECTION. **Section 22. Subrogation.** (1) It is the intent of the people to establish a single public payor for all health care in the state of Montana. However, until the role of all other payors for health care have been terminated, it is the intent of the people to recover health care costs from collateral sources whenever medical services are provided to an individual that are or may be covered services under a policy of insurance, health benefits plan, or other collateral source available to that individual or for which the individual has a right of action for compensation to the extent permitted by law.

(2) As used in [sections 23 through 28] and this section, the term "collateral source" includes all of the following:

(a) insurer, as defined in 33-1-201, including the medical components of automobile, homeowners, and other forms of insurance;

(b) health care and pension plans;

(c) employers;

(d) employee benefits contracts;

(e) government benefits programs, including but not limited to workers' compensation;

(f) a judgment for damages for personal injury; and

(g) any third party who is or may be liable to the individual for health care services or costs.

(3) The term collateral source does not include either of the following:

(a) a contract or plan subject to federal preemption as described in [sections 21, 75, and 87];

(b) a governmental unit, agency, or service to the extent that subrogation is prohibited by law.

An entity described in subsection (2) is not excluded from the obligations imposed by [sections 21, 75, and 87] by virtue of a contract or relationship with a governmental unit, agency, or service.

(4) It is the further intent of the legislature that the authority make every attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in Montana into the health security system.

NEW SECTION. **Section 23. Identification of collateral sources.** Whenever an individual receives health care services under the health security system for which a person is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the person shall notify the provider and the authority and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information as requested by the authority.

NEW SECTION. **Section 24. Assignment from collateral source.** Use of an eligibility card for or receipt of health care services under the health security system for which an individual is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source is considered an assignment by the individual to the health security system of the person's rights from or against the collateral source to the extent of services provided under [sections 1 through 82, 101, 104, and 105]. Any provision or agreement between the individual and the collateral source prohibiting assignment of rights is not applicable to an assignment under this section. Except as specified in [sections 21, 75, and 87], [sections 1 through 82, 101, 104, and 105] may not affect any person's right to benefits or money or right of action from or against a collateral source.

NEW SECTION. **Section 25. Reimbursement from collateral source.** (1) The health security system shall seek reimbursement from the collateral source for services provided to the individual and may institute appropriate action, including suit, to recover reimbursement. Upon demand, the collateral source shall pay to the health security fund any sums as it would have paid or expended on behalf of the individual for the health care services provided by the health security system.

(2) In addition to any other right to recovery provided in [sections 21, 75, and 87], the authority has the same right to recover the reasonable value of benefits from a collateral source as provided to the department of social and rehabilitation services in Title 52, chapters 2 and 4.

NEW SECTION. **Section 26. Collateral source services first.** If a collateral source is exempt from subrogation or the obligation to reimburse the health security system as provided in [sections 22 and 87] the authority may require that an individual who is entitled to medical services from the source shall first seek those services from that source.

NEW SECTION. **Section 27. Subrogation of retiree health benefits.** To the extent permitted by federal law, contractual retiree health benefits provided by employers are subject to the same subrogation as other contracts, allowing the health security system to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenue of the benefits directly to the health security system.

NEW SECTION. **Section 28. Integration of workers' compensation.** In the event of integration of workers' compensation health benefits into the health security system, the cost of workplace-related medical claims that are found to result from unsafe workplace conditions or negligence on the part of the employer must be borne by the employer rather than the health security system.

NEW SECTION. **Section 29. Revenue.** (1) Revenue to operate the health security system must be generated in a manner intended to coincide in the aggregate with financial responsibility for health care expenditures in the base year and may not exceed the limits described in [section 31].

(2) In the event of unanticipated expenditures in excess of the reserve account, or if cost control mechanisms indicated under [sections 49 through 51] are unable to lower expenditures without endangering the health of Montanans, the authority may request that the legislature increase health security system funding either by increasing tax rates on the sources described in [sections 83 through 100] or from other revenue sources.

(3) In the event that federal health care reform legislation is passed prior to or subsequent to [the effective date of this act], the authority shall take all steps necessary to ensure that all funds available to Montana for benefits and services covered under the federal health security system are paid to the health security fund.

(4) In the event of federal health care reform legislation including payroll, individual income, or cigarette and tobacco products taxation, and to the extent that agreements are reached to transfer those

revenues into the health security fund, the legislature may enact a proportional decrease in the payroll, individual income, and cigarette and tobacco taxes established pursuant to [sections 82 through 100] in order that revenue to the health security fund will be maintained within the limits established by [sections 31(1) and 77(3)].

NEW SECTION. **Section 30. Default.** Default, underpayment, or late payment of any tax or other obligation imposed by [sections 1 through 100] must result in the remedies and penalties provided by law.

NEW SECTION. **Section 31. Expenditure limits.** (1) It is the intent of the legislature that expenditures under the health security system not exceed in any year expenditures for the prior year adjusted for changes in the state gross domestic product and population.

(2) (a) If the reserve account is not fully funded, mandatory cost control measures as described in [section 51] must be triggered when the cumulative expenditures of the health security system, on an annualized basis, exceed 95% of the health security system budget exclusive of the reserve account, except during the last month of the fiscal year.

(b) If the reserve account is fully funded and during the last month of the fiscal year, mandatory cost control measures as described in [section 51] must be triggered only when cumulative expenditures of the health security system on an annualized basis exceed 100% of the health security system budget exclusive of the reserve account.

NEW SECTION. **Section 32. Preparation of budgets.** (1) The authority shall prepare an annual budget in the manner prescribed by law. The budget must include all of the following:

(a) a system budget that includes all expenditures for the health security system;

(b) regional budgets, that include all expenditures for the health security system within each system region;

(c) global budgets for each of the two principal mechanisms of professional provider reimbursement, fee-for-service and integrated health delivery system, and for individual health care facilities. The global budgets are part of the regional budget for each system region.

(d) a capital expenditure budget, as described in [section 48].

(2) The authority shall prepare the system budget for the health security system to be submitted

to the legislature as part of the governor's budget.

NEW SECTION. **Section 33. System budget.** (1) The cost of the health security system, including the cost of all services and benefits provided, administration, data gathering and other activities, and revenue deposited pursuant to [section 76], comprise the system budget.

(2) Money in the reserve account is not considered as available revenue for purposes of preparing the system budget.

NEW SECTION. **Section 34. Regional budgets.** (1) The authority, in consultation with the regional health care planning boards, shall propose a regional budget for each system region.

(2) The cost of all functions of the health security system within the system region, including the cost of all services and other benefits provided, administration, data gathering and other activities, and allocations to the system region from the health security fund comprise the regional budget.

(3) Funds available for system regions must be equally allocated among the system regions, on a per capita basis, adjusted for variations in population, demographics, incidence of disease, quality and availability of providers, reimbursement rates, and any other factor relevant to a particular system region as determined by the authority.

NEW SECTION. **Section 35. Global budgets.** (1) The authority, in consultation with the regional health care planning boards, shall prepare a regional budget for each system region. That budget must include allocations for each of the following:

(a) fee-for-service providers;

(b) capitated providers; and

(c) health care facilities that are not part of a capitated provider network.

(2) The allocations in subsection (1) must consider the relative usage of fee-for-service providers, capitated providers, and health care facilities that are not part of a capitated provider network within the system region. The global budgets must be adjusted from year to year to reflect changes in the use of services, changes in copayment for covered services, and the addition or exclusion of covered services made by the authority.

(3) The global budget for fee-for-service providers in each system region must be further divided

among categories of professional providers, establishing a total annual budget for each category within each region. Each of these category budgets must be sufficient to cover all included services anticipated to be required by eligible individuals choosing fee-for-service within the region, at the rates negotiated or set by the authority, except as necessary for cost containment purposes under [sections 49 through 51].

(4) The global budget for capitated providers must be sufficient to cover all eligible individuals choosing an integrated health delivery system within the system region, at the capitation rates negotiated or set by the authority, except as necessary for cost containment purposes under [sections 49 through 51].

(5) Each health care facility in a system region, apart from those that are part of capitated integrated delivery systems, must have a facility budget that encompasses all operating expenses for the health care facility. In establishing a facility budget, the authority shall develop and use separate formulas that reflect the differences in cost of primary, secondary, and tertiary care services.

NEW SECTION. **Section 36. Budget projections.** In preparing the budgets under [sections 32 through 38], the authority shall consider anticipated increased expenditures and savings, including but not limited to all of the following:

(1) projected increases in expenditures due to improved access for underserved populations and improved reimbursement for primary care;

(2) projected administrative savings under the single payor mechanism;

(3) projected savings in prescription drug expenditures under competitive bidding and a single buyer;

(4) projected savings in health care facility costs because of decreased acuity of hospitalization in some cases and appropriate availability of long-term care facilities in other cases;

(5) projected savings due to provision of primary care rather than emergency room treatment;

(6) projected savings from termination of reimbursement of procedures of no documented benefit or for which appropriate indications are not present;

(7) projected savings from diminished reimbursement for procedures and services of marginal benefit, as determined by the authority;

(8) projected savings from decreased reimbursement of specialty care relative to primary care; and

(9) projected savings because of regionalization of high-technology and experimental services.

NEW SECTION. **Section 37. Budget considerations.** In preparing the system budget, the authority shall also consider, in addition to changes in the state gross domestic product and population from year to year, anticipated additional expenditures due to medically appropriate increases in utilization, based on changes in disease incidence and prevalence among the population, and technological advances allowing better diagnosis and treatment of disease.

NEW SECTION. **Section 38. Administrative costs.** (1) Commencing with the second budget year, the administrative costs of the health security system incurred by the authority must be 4% or less of the total funds appropriated for the health security system. If administrative costs exceed this target, the authority shall report to the legislature the reasons for excess administrative costs.

(2) That amount of the system budget remaining after funds are allocated for administration and data gathering must be budgeted for the system regions, in the manner described in [section 34], to provide benefits pursuant to [sections 9 through 14].

NEW SECTION. **Section 39. Professional provider reimbursement.** (1) Professional providers registered for reimbursement with the system shall, with respect to all covered services provided to an eligible individual under [sections 9 through 14], do all of the following:

(a) submit all bills to the administrator pursuant to procedures established by the authority;

(b) not charge the system an amount in excess of rates negotiated or set by the authority;

(c) not charge the patient any additional amount or copayment except as specified under [sections 11 and 65] and by rule.

(2) Professional providers registered for reimbursement under the system who have submitted bills for covered services in accordance with the guidelines established by the authority must be paid promptly. Interest accrues on all bills that are 45 days past due at the rate of 1% a month.

NEW SECTION. **Section 40. Choice in basis for reimbursement -- negotiations -- surplus.** (1) Health care facilities registered with the health security system may choose to be reimbursed on the basis of either a facility budget for all covered services rendered under the health security system based on standards and criteria adopted by rule pursuant to [section 35] or as a capitated integrated professional provider network pursuant to [section 41(3)].

(2) The budget specified in subsection (1) must be negotiated with each participating health care facility on an annual basis, with adjustments during the year made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population at the discretion of the authority.

(3) Surplus generated from the operating section of a health care facility budget may not be used for the payment or reimbursement of any capital cost, except in accordance with the provisions of [sections 47 and 48].

(4) Any surplus that a health care facility may be able to generate through increased efficiency of operation may be used to develop new and innovative programs, as approved by the authority, or must be returned to the health security system.

(5) Health care facilities shall inform the authority as soon as evidence suggests that operating expenses will exceed the facility budget.

(6) (a) Any real or projected operating deficit as a result of a health care facility exceeding the facility budget must be investigated by the authority. If it is determined that the deficit reflects appropriate increased use of services, the facility budget for the health care facility must be adjusted and appropriately revised in the current or subsequent year, or both, to cover the anticipated shortfall.

(b) To the extent that it is determined that the operating deficit was not justifiable under the policies and terms of the health security system, adjustments in the facility budget may not be made. Instead, recommendations for improved efficiency or other changes necessary to bring costs within the health care facility budget may be made by the authority. Implementation of these recommendations may be a precondition for funding in the next health security system year.

(7) (a) Each health care facility budget must allow for care of individuals who are not enrolled in the health security system or are not eligible for services at the same rates as for enrolled individuals as necessary to provide emergency care and to protect the health and safety of the population as a whole.

(b) A health care facility that fails to provide full access to all individuals pursuant to subsection (6)(a) must be investigated by the authority and may be barred from receiving health security system funds in subsequent years, at the discretion of the authority, subject to the review procedures in [section 44].

NEW SECTION. **Section 41. Payment mechanisms.** (1) Physicians, advanced practice nurses, and other independent professional providers may choose from a variety of payment mechanisms for

reimbursement. These payment methods may include but need not be restricted to fee-for-service, capitation, or a salary from a globally budgeted health care facility for a defined level of service. [Sections 1 through 82, 101, 104, and 105] may not be construed to permit discrimination in eligibility for reimbursement against a class of professional providers who are providing services within the scope of practice permitted by law.

(2) The authority may require that all care under fee-for-service payment be coordinated by a designated primary care provider and that all individuals select a primary care provider. The primary care provider may be an individual professional provider or a group of professional providers. Under these arrangements, care provided by specialists without referral from a designated primary care provider must be reimbursed at the primary care rate rather than that for specialty care.

(3) (a) An individual professional provider or a group of professional providers may elect to be paid a prospective payment on a capitated basis for all individuals enrolling for care from that professional provider or group of professional providers. Providers accepting payment on a capitated basis cannot also be paid on a fee-for-service basis. All patients receiving care from professional providers participating under prepaid arrangement shall do so on a capitated basis. A formal enrollment process must be adopted in which individuals voluntarily designate the individual professional provider or group of professional providers for prepaid care. Individuals enrolling under prepaid arrangements must receive their care from the designated prepaid practice or professional providers authorized by the prepaid practice.

(b) The fee level for capitated reimbursement must be negotiated annually by professional provider organizations and the authority or set by the authority and must apply uniformly to all professional providers in the system region. The capitated fee level must be adjusted based on the health risk of enrollees, scope of ambulatory services provided by the professional provider, and any other relevant factors. At a minimum, the scope of services covered by the capitated payment must include all primary care services. Capitated contracts may include stop-loss measures for catastrophic expenses and any other measures necessary to maintain fairness and fiscal stability.

(4) Compensation for professional providers who provide services as employees of or under contract to health care facilities must be covered under the facility budget of those health care facilities.

NEW SECTION. **Section 42. Representation of providers in negotiations.** (1) The authority shall recognize professional associations to represent professional providers in each system region in negotiations

with the authority on reimbursement and other professional issues.

(2) The authority shall establish procedures allowing each category of professional provider in a system region to choose, by majority vote of that category of professional provider, the organization or association in each region that may be their representative in all negotiations with the authority.

(3) All professional provider associations may participate in annual negotiations. All professional providers within a category are bound by the results of the negotiations between the authority and the association representing that category of professional provider.

(4) In the event that negotiations with professional providers and others are not concluded in a timely manner, the authority may set rates, fees, and prices for services reimbursed by the health security system.

NEW SECTION. **Section 43. Limits on aggregate payments.** (1) Notwithstanding [section 42], the authority shall establish a limit on the aggregate annual payments to an individual professional provider or discounts on reimbursements above a specified amount of aggregate billing, as negotiated with the professional associations.

(2) An individual professional provider whose billing volume or distribution suggests the possibility of impropriety may be subject to investigation by the authority and may be subject to exclusion or other penalties pursuant to [sections 56 through 63].

NEW SECTION. **Section 44. Integrated delivery systems allowed.** (1) (a) A health care facility and a group of physicians and other professional providers may organize as an integrated delivery system providing the full spectrum of health care services to a defined population of enrollees. An integrated system may be paid by the health security system on a capitated basis to provide the full spectrum of benefits covered by the health security system. [Sections 1 through 82, 101, 104, and 105] may not prevent an integrated delivery system from offering benefits beyond those set forth in [sections 9 through 14]. The fee level for capitated reimbursement must be negotiated on a regional basis by professional provider associations and the authority, based on health risk of enrollees and any other relevant factors, and must apply uniformly to all professional providers in the region.

(b) Health care facilities participating under this capitated arrangement as part of an integrated delivery system are exempt from negotiating separate operating budgets with the health security system.

However, they are not exempt from regulation of capital investment as specified in [sections 47 and 48].

(2) (a) The profits of health care facilities and professional providers organizing as integrated delivery systems that are for-profit are restricted to a fair rate of return to be negotiated with the authority and are subject to the same restrictions on capital expansion that apply to all other health facilities, clinics, and professional providers.

(b) Health care facilities and providers organizing as an integrated delivery system that are for-profit must be capitated or facility budgeted by the same criteria and at the same rates as nonprofit entities.

(3) If any professional provider involved in an integrated system has an existing collective bargaining agreement or agreements, those collective bargaining agreements may be extended to the employees of all of the professional providers in the integrated system, unless otherwise prohibited by law.

(4) [Sections 1 through 82, 101, 104, and 105] may not prevent the authority, after public hearings, from termination of the participation of a health care facility in the health security system should credible evidence lead the authority to conclude either of the following:

(a) that the health care facility or clinic is unable to meet minimum requirements relating to the number and type of professional providers on the staff, the type of equipment available to the facility or the range of specialty services provided by the facility, or other standards and criteria adopted by rule; or

(b) that the health care facility provides care significantly below the standard for facilities in the region.

(5) The authority shall by rule develop different standards and criteria pursuant to subsection (4) for urban and rural health facilities. Under the circumstances of subsection (4), the authority may authorize conversion of the facilities to meet health care needs.

NEW SECTION. **Section 45. Voluntary enrollment under capitated payment arrangements.** (1) The authority shall provide clear and well-publicized procedures in which individuals eligible for benefits under the health security system may voluntarily enroll under capitated payment arrangements with a specified professional provider, group of professional providers, or integrated delivery system. Individuals are entitled to disenroll from capitated practices during the period specified in subsection (2). Enrollment and disenrollment must be administered by the health security system and not delegated to professional providers or professional provider associations for the purposes of processing or otherwise administering enrollment and disenrollment procedures.

(2) Every 6 months, individuals enrolled in a capitated practice are entitled to an open enrollment period of not less than 2 weeks, pursuant to rules adopted by the authority.

(3) During the open enrollment period, an individual may enroll in another capitated practice or choose a primary care provider in the fee-for-service sector.

(4) An individual who has selected a primary care provider in the fee-for-service sector may choose to switch to enrollment in a capitated practice at any time.

(5) Any professional provider accepting payment from the health security system on a prepaid basis shall allow any eligible individual to enroll in the order of application, up to a reasonable limit determined by the capacity of the capitated practice to provide services.

(6) Providers accepting payment from the health security system on a prepaid basis, as a condition of approval to participate in the provision of benefits under [sections 1 through 82, 101, 104, and 105], shall demonstrate that they will provide or arrange and pay for all of the benefits required for the capitation payment negotiated or set by the authority.

(7) [Sections 1 through 82, 101, 104, and 105] may not prohibit an integrated delivery system or other capitated practice from offering additional benefits beyond those set forth in [sections 9 through 14]. The additional benefits must be clearly set forth in disclosure and practice description materials provided to individuals eligible for services under [sections 1 through 82, 101, 104, and 105].

NEW SECTION. **Section 46. Financial incentives for community and rural services.** (1) The authority shall incorporate into the reimbursement policies specific financial incentives for professional providers to perform community outreach and preventive services. As a condition of receiving the incentives, professional providers shall coordinate their efforts with those of the department of health and environmental sciences, local health departments, and other agencies in a manner specified by the authority.

(2) (a) The authority shall reimburse collaborative practice costs to meet the objectives of community-oriented primary care, including the costs of visiting health workers and public health nurses working with primary care providers, including physicians, advanced degree nurses, and physician assistants-certified.

(b) The authority may institute reimbursement mechanisms that have as their purpose improving the availability of health care services to underserved areas and populations.

(3) The authority shall consider the special needs and requirements of rural hospitals in Montana that are financially distressed and in danger of closure. The authority may provide technical assistance with respect to the reimbursement and other requirements and procedures of the health security system to financially distressed rural hospitals, when appropriate, in order to preserve the availability of health care services.

NEW SECTION. **Section 47. Capital expenditures.** (1) (a) The purpose of this section is to ensure that health care facilities that are reimbursed by the health security system do not engage in unnecessary capital expenditures and thereby contribute to health care cost inflation. The provisions of Title 50, chapter 5, part 3, do not apply to a facility under this section.

(b) As of [the effective date of this act], a licensed health care facility or any individual acting on behalf of a licensed health care facility may not incur a capital expenditure and a health care facility may not receive health facility development loans, pursuant to Title 90, chapter 7, without obtaining the prior approval of the authority.

(c) The authority shall exclude from any reimbursement under [sections 1 through 82, 101, 104, and 105] amounts for capital expenditures, operating expenses for capital improvements, and the cost of services provided by those capital improvements made or incurred by a health care facility or provider after [the effective date of this act], unless that capital expenditure was approved by the authority.

(d) As used in this section, the term "capital expenditure" is an expenditure that under generally accepted accounting practices is not properly chargeable as an expense of operation and maintenance and that does any of the following:

(i) exceeds $500,000;

(ii) changes the bed capacity of the facility with respect to which the expenditure is made; or

(iii) adds a new service or license category.

(e) For purposes of this section, the cost of studies, surveys, design plans and working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which the expenditures are made must be included in determining whether the expenditure exceeds the dollar amount specified in this section.

(f) When a health care facility or individual acting on behalf of a health care facility obtains by lease or comparable arrangement any facility or part of a facility or any equipment for a facility the market value

of which would have been a capital expenditure, the lease or arrangement must be considered a capital expenditure for purposes of this section.

(2) The authority shall approve a capital expenditure only if it is in conformity with standards, criteria, and plans developed by the authority to accomplish one or more of the following:

(a) fill unmet needs;

(b) eliminate duplicative, inappropriate, or unnecessary services by regionalizing services in appropriate facilities;

(c) encourage the expansion of those facilities that have superior records of consumer satisfaction and operating efficiency;

(d) convert to nonacute care uses general acute care hospitals of less than 150 licensed beds within standard metropolitan statistical areas;

(e) ensure that health care facilities are accessible to all parts of the community, including the disabled and populations with special medical needs;

(f) promote joint, cooperative, or shared health care resources;

(g) ensure the development of new technologies in appropriate facilities; and

(h) meet the special needs of rural hospitals.

(3) (a) The authority shall establish procedures for the review of capital expenditures.

(b) The procedures may provide that all capital expenditures in a particular region or for one or more particular purposes submitted over a period of time of up to 1 year may be reviewed together at the same hearing.

(4) Notwithstanding the provisions of subsection (2), the authority may approve capital expenditures for either of the following reasons:

(a) if necessary to meet parking, seismic safety, fire safety, physical accessibility for the disabled, energy or water conservation, or other public health and safety requirements of federal, state, or local government; or

(b) if necessary to replace a physical plant and equipment damaged or destroyed by fire, earthquake, or other natural disaster.

(5) Notwithstanding any other provision of law, the authority may approve the temporary or permanent conversion of general acute care beds to skilled nursing beds or the addition of skilled nursing beds to any general acute care hospital.

NEW SECTION. **Section 48. Capital allocation.** (1) Once a capital expenditure request has been approved by the authority, it may be funded.

(2) No later than January 1 of [the second year following the effective date of this act], the authority shall report on the capital needs of health facilities and clinics in each system region. In addition to any other matter considered relevant by the authority, the report must identify the capital needs of all of the following:

(a) county health care facilities;

(b) underserved geographic areas with per capita investment in health care facilities substantially different from the state average; and

(c) geographic areas where the distance to health care facilities imposes a barrier to care.

NEW SECTION. **Section 49. Cost control measures.** The authority may not carry out any cost control measure that limits access to care that is needed on an emergency or urgent basis or that is medically appropriate for treatment of a patient's medical condition.

NEW SECTION. **Section 50. Cost control.** (1) In order to control costs, the authority shall strive at all times to do all of the following:

(a) eliminate administrative and other costs that do not contribute to health care;

(b) identify and eliminate wasteful and unnecessary care that does not benefit patients receiving that care; and

(c) identify and foster those measures that prevent disease and maintain health.

(2) (a) In the event that the measures taken pursuant to subsection (1) are insufficient to maintain the fiscal integrity of the health security system, the authority shall study the contribution of inappropriately provided services to escalating costs. The authority shall adjust the next year's budget, pursuant to [sections 32 and 36], to correct for the degree of overuse identified for particular services or particular categories of licensed providers under particular modes of reimbursement.

(b) Restrictions in budgets under subsection (2)(a) may be employed only to the extent necessary to correct for the proportion of cost increase in excess of that resulting from appropriate use, based on incidence of illness in the population, that is caused by the particular services, category of provider, or mode of reimbursement being restricted, as determined by the authority.

NEW SECTION. **Section 51. Request to legislature for increased appropriation.** (1) In the event that cost control is required by [section 31(2)], the authority may request that the legislature increase appropriations for the health security system. Any request must be accompanied by a report on the causes of the increase in expenditures beyond the increase in gross domestic product, adjusted for population, and measures taken to control costs pursuant to [section 50].

(2) In the event that the actions taken pursuant to [section 50] and subsection (1) of this section are insufficient to contain costs or increase revenue, the authority may, as necessary, defer funding of the reserve account for a period not to exceed 1 year and may establish restrictions or copayments on elective services.

(3) Restrictions on and copayments for elective services, as necessary to balance the system budget, must be applied by the authority in order of increasing efficacy, as determined by the authority, in order that those elective services that are clearly beneficial for treatment of a patient's condition are the last services to be restricted or to have a copayment applied.

(4) Measures taken under [section 50] and subsection (2) of this section may not be used to restrict coverage of a specific diagnosis, unless the authority finds both of the following:

(a) that the diagnosis or the available treatments are often inappropriate; and

(b) that a means of distinguishing appropriate from inappropriate use of services for the diagnosis is established based on recommendations of the authority.

NEW SECTION. **Section 52. Primary care.** The legislature finds that quality and efficiency in the delivery of health care services can best be achieved when the ratio of primary care to specialist physicians is one-to-one. Accordingly, the authority shall develop and implement appropriate policies that are intended to achieve this ratio.

NEW SECTION. **Section 53. Tertiary care.** (1) The authority shall designate one or more tertiary care referral centers for the state at which particular specialized, experimental, high-technology, and high-expense procedures and services may be performed based on the expertise available and the outcomes demonstrated at those centers.

(a) The authority shall guarantee that specialized, experimental, high-technology, and high-expense procedures and services are performed at the highest level of competency possible and are fully available

to all Montanans with conditions whose effective treatment requires that care.

(b) The authority shall guarantee that the specialized services available in tertiary care referral centers are not in oversupply or otherwise available in ways that are likely to foster their inappropriate use.

(c) Tertiary care referral centers include but need not be limited to county hospitals in the region unless the authority finds compelling reasons to designate otherwise.

(2) The services for which reimbursement is restricted to the designated tertiary care referral centers must be determined and specified no less than yearly by the authority.

(3) The authority shall take the measures that are necessary to ensure that regionalization of specialized services does not result in barriers to appropriate and reasonable access to those services.

NEW SECTION. **Section 54. Public health.** (1) The regional health care planning boards shall make recommendations to the authority on technology assessment, cost-effectiveness, practice guidelines and standards, and promotion of population-based health strategies with an emphasis on prevention. Funding to carry out these recommendations and to carry out public health research to promote disease prevention strategies must be budgeted from the health security fund in the form of grants for specific programs of the department of health and environmental sciences, county health departments, or other state or local government or private, nonprofit human services agencies or grants to programs established directly by the authority.

(2) It is the intent of the legislature that funding by the authority of new programs under the auspices of the department of health and environmental sciences, county health departments, or other state or local government or private, nonprofit human services agencies not be used to reduce existing funding for these departments and agencies.

NEW SECTION. **Section 55. Primary care, tertiary care, and public health.** The authority may establish by rule standards and criteria regarding any aspect of primary care, tertiary care, and public health not specified in [sections 52 through 55].

NEW SECTION. **Section 56. Enforcement.** (1) A provider that receives funds or provides care pursuant to [sections 1 through 82, 101, 104, and 105] may not discriminate against a person seeking care on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, medical

condition, marital status, sex, sexual orientation, age, wealth, or any other basis prohibited by the civil rights laws of this state. [Sections 1 through 82, 101, 104, and 105] may not require a professional provider or health care facility or clinic to perform a particular service when either of the following applies:

(a) the particular service is outside its scope of practice that is limited to certain medical specialties, services, or age groups;

(b) the professional provider or health care facility or clinic asserts a religious or conscientious objection to providing the particular service.

(2) A person who is eligible for health care services under [sections 1 though 82, 101, 104, and 105] has the right to equitable access of medically appropriate health care and has standing to enforce this section.

NEW SECTION. **Section 57. Rules for financial interest in health care facilities -- disclosure by providers.** (1) Standards and criteria must be established by rule to ensure that health care providers may not have a financial interest in laboratory and diagnostic facilities to which they refer patients for tests, procedures, or services.

(2) Standards and criteria must be established by rule regarding financial disclosure by any health care facility or professional provider reimbursed under the health security system in order to safeguard patient care and the integrity of the system.

NEW SECTION. **Section 58. Mandatory exclusion of providers.** The authority shall exclude the following providers from participation in any program under [sections 1 through 82, 101, 104, and 105]:

(1) a provider that has been convicted, under either state or federal law, of a criminal offense relating to any of the following:

(a) the delivery of an item or service under the act or any other federal or state health care program;

(b) the neglect or abuse of a patient in connection with the delivery of health care;

(c) fraud, theft, embezzlement, breach of financial responsibility, or other financial misconduct in connection with the delivery of health care or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, state, or local government agency;

(d) the interference with or obstruction of any act of the authority; and

(e) the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(2) a provider whose license to provide health care has been revoked or suspended by any state licensing agency or who otherwise lost a license or the right to apply for or renew a license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity;

(3) a provider that has been suspended or excluded from participation in any federal or state program involving the provision of health care, including but not limited to medicare, medicaid, and programs of the federal departments of defense and veterans affairs.

(4) a provider that the authority determines has done any of the following:

(a) has submitted or caused to be submitted to the authority bills or requests for payment for items or services furnished when the bills or requests are based on charges or costs in excess of permitted charges or costs, unless the authority finds there is good cause for the bills or requests;

(b) has furnished or caused to be furnished to patients items or services that are substantially in excess of the needs of the patients or of a quality that fails to meet professional recognized standards of health care; and

(c) is a health maintenance organization or other capitated program and has failed substantially to provide medically necessary items and services that are required under [sections 1 through 82, 101, 104, and 105] to be provided to eligible individuals if the failure has adversely affected or has had a substantial likelihood of adversely affecting those individuals;

(5) a provider that did not fully or accurately make any disclosure required to be made under [sections 1 through 82, 101, 104, and 105]; and

(6) a provider that fails to grant the authority access, upon reasonable request of the authority and pursuant to rules adopted by the authority, to enable the authority to do any of the following:

(a) review data and records relating to compliance with conditions for participation and payment;

(b) perform the reviews and surveys required by [sections 1 through 82, 101, 104, and 105]; or

(c) review records, documents, and other data necessary to the performance of the statutory functions of the authority.

NEW SECTION. **Section 59. Discretionary exclusion of providers.** The authority may exclude the following providers from participation in any program under [sections 1 through 82, 101, 104, and 105]:

(1) a provider found to violate [section 56 or 57].

(2) a person, including an organization, agency, or other entity but excluding a covered individual, that presents or causes to be presented to an officer, employee, or agent of the authority a claim or request for payment that the authority determines meets any of the following descriptions:

(a) the claim or request for payment is for a service or item that the person knows or should know was not provided as claimed;

(b) the claim or request for payment is for a service or item and the person knows or should know the claim is false or fraudulent;

(c) the claim or request for payment is presented for a physician's service or an item or service incident to a physician's service by a person who knows or should know that the individual who furnished or supervised the furnishing of the service was not licensed as a physician or was not certified in a medical specialty by a medical specialty board when the individual was represented as certified or the individual had been previously excluded from participation; or

(d) the claim or request for payment is in violation of [sections 1 through 82, 101, 104, and 105] or any regulation issued under [sections 1 through 82, 101, 104, and 105].

(3) (a) any person, including an organization, agency, or other entity but excluding a covered individual, that does any of the following:

(i) makes a payment or provides an item or service, directly or indirectly, to any other provider as an inducement to reduce or limit the service provided to a covered individual under the health security system;

(ii) offers to pay or solicits or receives any remuneration, including but not limited to any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for either of the following:

(A) referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment is made under the health security system; or

(B) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering of any good, facility, service, or time for which payment may be made in whole or in part under the health security system.

(b) this subsection (3) may not apply to any of the following:

(i) a discount or other reduction in price obtained by a provider of service or other entity if the

reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the health security system;

(ii) an amount paid by an employer to an employee, who has a bona fide employment relationship with that employer, for employment in the provision of covered items and services;

(iii) any other agreement or payment practices that the authority determines, pursuant to rules adopted by the authority, are not primarily intended to induce or influence the quantity or quality of services provided under the health security system.

(4) a provider found to provide substandard care or engage in unprofessional conduct. Standards and criteria must be established by rule to review the care provided by providers to detect potential and actual quality of care problems and to prevent overuse or underuse of services paid for by the health security system.

NEW SECTION. **Section 60. Civil penalties.** In addition to any other penalties prescribed by law, the authority may impose a civil money penalty of not more than $5,000 for each violation of [sections 56 through 63]. In addition, a person who violates [sections 56 through 63] is subject to an assessment of not more than twice the amount of unlawful payment or damages sustained by the state resulting from the violation. In addition, the authority may make a determination in the same proceeding to exclude the person from participation in the health security system.

NEW SECTION. **Section 61. Rules for review of exclusion.** (1) The authority shall establish regulations and procedures for the review of any action that may result in exclusion or penalties under [sections 56 through 63].

(2) In the case of exclusion or limitation under [section 59(4)], the review procedures must be consistent with those required by Title 37. The authority and all other individuals participating in the review procedures have all the immunities provided to a hospital by 37-2-201 and 37-3-401 through 37-3-404.

(3) In the case of exclusion, limitation, or penalty for any other reason permitted by [sections 56 through 63], the review procedures must be consistent with [section 69].

NEW SECTION. **Section 62. Exclusion -- termination.** (1) An exclusion must be effective at the time and upon the conditions as the authority determines.

(2) An exclusion may be terminated at the time and upon the conditions as the authority determines.

NEW SECTION. **Section 63. Notice of exclusion.** (1) The authority shall provide notice to the public of all exclusions in accordance with rules adopted by the authority.

(2) The authority shall file a report pursuant to 37-3-401 with respect to any professional provider whose participation in the health security system has been limited in any way or who has been excluded from participation.

NEW SECTION. **Section 64. Phasein -- initial health security system budget.** (1) The authority shall seek from the legislature sufficient appropriation for startup expenditures and transition costs.

(2) Any money appropriated under subsection must be repaid with interest to the general fund from the health security fund within 2 years unless a longer period is authorized by the legislature.

NEW SECTION. **Section 65. Phasein -- benefits.** (1) Benefits provided in [sections 9 through 14] must be available to eligible individuals beginning January 1 of [the second year following the effective date of this act].

(2) During the first year of benefits under the health security system, the authority may establish copayments as follows:

(a) for any elective service or prescription drug, not to exceed $5 for each procedure or prescription;

(b) for outpatient mental health care services, after the 26th service rendered in the year, not to exceed:

(i) in the case of services rendered by fee-for-service providers, 50% of the fee charged for each visit or rendered service;

(ii) in the case of services rendered by capitated providers, $25 per visit or rendered service.

(3) Individuals who receive benefits under the federal medicare program, the CHAMPUS program, or the federal employees' health benefits plan or who are exempt from copayments under federal law may not be required to pay the copayments specified in this section.

(4) After the first year of benefits under [sections 1 through 82, 101, 104, and 105], a copayment

may not be required for any covered benefit, other than as established by the authority pursuant to [section 11]. However, the authority may extend the period of copayment under subsection (2) of this section for up to 1 additional year upon making a finding that the health security system is not yet capable of absorbing the full cost of the benefits.

NEW SECTION. **Section 66. Health care worker staffing ratio changes.** (1) Beginning [the effective date of this act], a health care facility or professional provider may not increase the ratio of patients to licensed or registered nurses without the approval of the authority. Petitions for waivers must be made public and may not be approved without 60 days' public notice.

(2) Prior to the date benefits are first available under the health security system, the authority shall establish minimum safe staffing standards for all settings in which health care is provided including minimum public health staffing standards.

NEW SECTION. **Section 67. Transition of capitated integrated health systems.** (1) An individual enrolled in a capitated integrated health delivery system on December 31 of [the first year following the effective date of this act] must be considered enrolled in that integrated health delivery system for the purposes of initial benefits effective January 1 of [the second year following the effective date of this act], unless the particular integrated delivery system in which the individual is enrolled has not been registered by the health security system or has selected a noncapitated mode of reimbursement under the health security system.

(2) The authority shall meet with representatives of registered integrated health care delivery systems in each system region no less than 4 months prior to providing initial benefits under the health security system for the purposes of coordinating the systems' transition to the health security system.

(3) The authority shall consider the special needs and requirements of capitated integrated health care delivery systems in Montana. The authority may provide technical assistance or adopt rules with respect to the reimbursement and other requirements and procedures of the health security system to ease the transition of capitated integrated health care delivery systems in order to preserve the availability of health care services in Montana.

NEW SECTION. **Section 68. Hearings and judicial review.** (1) Any person aggrieved by a decision,

order, rate, rule, regulation, action, or failure to act of or by the authority or a regional health care planning board may seek judicial review.

(a) A decision that is required by law to be made following a quasi-adjudicatory hearing may be set aside only if it is not supported by substantial evidence. Any other decision, order, rate, rule, regulation, action, or failure to act may be set aside only if it is arbitrary and capricious.

(b) In suits brought by one or more individuals contesting an action of the authority restricting coverage afforded them under this program, a prevailing plaintiff must be awarded costs of suit and reasonable attorney fees.

(2) In any action or proceeding challenging a legislative amendment to [sections 1 through 82, 101, 104, and 105], the following apply:

(a) The party or parties asserting the validity of the amendment has the burden of proving by clear and convincing evidence that the amendment is consistent with the purposes of [sections 1 through 82, 101, 104, and 105]. The purposes of [sections 1 through 82, 101, 104, and 105] include not only the intent, findings, and declarations set forth in [sections 2 and 3], but also the means the acts employed to achieve the stated aims.

(b) A legislative amendment that is inconsistent with the purposes of [sections 1 through 82, 101, 104, and 105] must be declared invalid, and the prevailing plaintiff, other than the authority, an officer, or a member of a department, board, or agency established by [sections 1 through 82, 101, 104, and 105] must be awarded cost of suit and reasonable attorney fees.

NEW SECTION. **Section 69. Hearings.** (1) Any quasi-adjudicatory hearing required by law must be conducted in accordance with Title 2, chapter 4, except as provided in [sections 1 through 82, 101, 104, and 105].

(2) The hearing must be conducted by a hearing officer assigned by the authority. The hearing officer rules on the admission and the exclusion of evidence and may exercise all other powers relating to the conduct of the hearing.

NEW SECTION. **Section 70. Insurance and practice outside the health security system.** (1) Any person providing or offering health care or insurance to any individual for a fee or other consideration that covers benefits available under the health security system shall inform these individuals, including

prospective customers, in writing of the benefits for which they may be eligible under the health security system.

(2) The authority may establish a uniform notice as described in subsection (1), specifying both content and print size, to be posted at any place of business or included in any advertisement, policy of insurance, or offer to insure. The notice must be limited to an advisement of rights under [sections 1 through 82, 101, 104, and 105] and the name and phone number of a person or office that can provide further information.

(3) Failure to provide the notice required by this section constitutes an unfair business practice, entitling the individual to rescission, restitution, damages, and other remedies as provided by law and may result in other action by the authority as authorized by law.

NEW SECTION. **Section 71. Open participation.** Any health care facility or professional provider may elect to participate in the health security system unless excluded by the authority.

NEW SECTION. **Section 72. Payment and provision of services.** (1) Except as provided in [section 21], a participating health care facility or professional provider may not charge any person, including individuals not eligible for benefits under the health security system, for services or procedures that are covered benefits under the health security system, other than for a copayment as permitted.

(2) Except as provided in [section 39], a participating health care facility or professional provider may provide to any person services or procedures that are not covered benefits under [sections 1 through 82, 101, 104, and 105], subject to the following conditions:

(a) A provider may require a patient to pay for services or procedures that the authority has determined are not covered by the health security system. Fees or reimbursement for a service or procedure not covered under the health security system is a matter between the provider and the patient. The health security system is not liable for these charges and may not be billed.

(b) A provider may not require a patient to pay for or obtain a service not covered by the health security system as a condition of obtaining covered services.

(c) The authority may monitor the provision, frequency, and cost of services under this subsection (2) to determine their efficacy and possible inclusion as covered benefits and to safeguard against abuse of the health security system.

NEW SECTION. **Section 73. Coordination with other laws -- exemption from state and federal antitrust laws.** (1) An action taken by or on behalf of the authority or by any person as authorized by [sections 1 through 82, 101, 104, and 105] may not be considered a violation of unfair trade practices.

(2) It is the intent of the legislature to ensure that all Montanans receive high-quality health care coverage in the most efficient and cost-effective manner possible.

(a) In furtherance of this intent, the legislature finds and declares that it is in the public interest to enhance the ability of professional providers and health care facilities to form bargaining units for the purpose of contracting for the delivery of health care services and that it is in the public interest for the health security system to contract with vendors, professional providers, and health care facilities to further the purposes of [sections 1 through 82, 101, 104, and 105].

(b) The legislature further finds and declares that the existing marketplace for health care services, relying on contracts between individual providers, both institutional and professional, and individual insurers and purchasers has not proven effective and has been unable to provide quality and efficient health care to all Montanans.

(c) The legislature further finds and declares that the efficient operation of the health security system, including its salient purpose of providing universal, comprehensive, accessible, portable, and publicly administered health care and providing the greatest freedom of choice to the health care consumer, requires the displacement of competition among providers, insurers, and purchasers of health care services.

(d) It is the intent of the legislature, that the formation of groups and combinations of providers and health care facilities and the concentration of purchasing power and regulatory authority in the health security system should be exempt from federal antitrust restraints.

(3) The legislature finds and declares all of the following:

(a) There is a compelling state public interest in each action undertaken by or on behalf of the authority and every other state and local agency, board, council, and officer acting under and in furtherance of [sections 1 through 82, 101, 104, and 105], including but not limited to those actions otherwise considered in restraint of trade.

(b) [Sections 1 through 82, 101, 104, and 105] prescribe and exercise the degree of state direction and supervision over health care services that provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under the health security system.

(4) This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the groups or combinations any person who is lawfully qualified to perform the services to be performed by the members of the group or combination when the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

NEW SECTION. **Section 74. Compliance with federal health care reform legislation.** (1) The authority shall determine those provisions of [sections 1 through 82, 101, 104, and 105], and those actions taken pursuant to [sections 1 through 82, 101, 104, and 105] that must be modified to achieve compliance with requirements for state health plans as specified by federal laws or regulations, including those enacted after [the effective date of this act].

(a) If any statutory provision of [sections 1 through 82, 101, 104, and 105] must be modified to achieve compliance with federal health care reform legislation, the authority shall seek appropriate amendment by the legislature, preserving the goals of the health security system, including but not limited to providing universal and comprehensive coverage, cost control, fiscal soundness, and progressive financing.

(b) The authority shall construe or modify any regulation promulgated under [sections 1 through 82, 101, 104, and 105] as necessary to achieve compliance with federal health care reform legislation.

(2) Provisions of federal laws and regulations covered by this section include but are not limited to certifying health plans, financing and financial solvency, cost control, protection for health care providers and enrollees, health benefits, enrollment, and provider reimbursement.

NEW SECTION. **Section 75. Federal waivers.** (1) The authority shall seek all appropriate federal waivers, exemptions, agreements, or legislation that will allow all federal payments for medical, mental health, and long-term care made in this state to be paid directly to the authority for the purposes of the health security system and that will allow for the assumption by the health security system of the responsibility for all benefits previously paid by the federal government.

(2) The authority shall, in all cases, seek to maximize federal contributions and payments for medical, mental health, and long-term care services provided in this state, and in obtaining the waivers, exemptions, agreements, or legislation required by subsection (1), the authority shall seek to ensure that

the contributions of the federal government for medical, mental health, and long-term care services in Montana may not decrease in relation to other states as a result of the waivers, exemptions, agreements, or legislation.

(3) (a) The authority shall pursue all reasonable means to secure repeal or waiver of any provision of federal law that preempts any provision of [sections 1 through 82, 101, 104, and 105].

(b) In the event repeal or waiver cannot be secured, the authority shall exercise its powers to promulgate rules or seek conforming state legislation that are consistent with federal law in an effort to best fulfill the purposes of [sections 1 through 82, 101, 104, and 105].

NEW SECTION. **Section 76. Health security fund account.** (1) There is a health security fund account in the state treasury for the administration and enforcement of [sections 1 through 82, 101, 104, and 105].

(2) All collections of the tax imposed under [sections 83 through 100], interest and penalties on the taxes, and revenue appropriated to the account under [section 77] must, in accordance with the provisions of 15-1-501(6), be deposited in the health security fund.

(3) (a) There is a reserve account within the health security fund. The reserve account is considered to be fully funded when it contains not less than 5% of the total health security system revenue in a given year.

(b) The authority shall retain the reserve account for budgetary shortfalls in the health security system, for epidemics, or for other extraordinary circumstances as defined by the authority and as provided in [section 77]. The authority's proposed budget must contain funding for the reserve account equal to 1% of the system budget unless the authority determines that a different amount is needed for the prudent operation of the health security system.

NEW SECTION. **Section 77. Appropriations.** (1) It is the intent of the legislature that all money in the health security fund be appropriated to the health security system to support implementation of [sections 1 through 82, 101, 104, and 105].

(2) The legislature may appropriate additional money from the general fund or from other sources to support the implementation of [sections 1 through 82, 101, 104, and 105].

(3) After full phasein of benefits under [sections 9 through 14], if for each of 2 consecutive years

the balance remaining in the health security fund at the end of the fiscal year is greater than 1% of the system budget and the reserve account is fully funded, the authority shall request that the legislature reduce the tax rates in [sections 82 through 100].

NEW SECTION. **Section 78. Federal contributions to health security fund.** The authority shall seek all necessary waivers, exemptions, agreements, or legislation to allow all current federal payments for health care to be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the authority shall seek from the federal government a contribution for health care services in Montana that may not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

NEW SECTION. **Section 79. State contributions to health security fund.** (1) The authority shall seek all necessary waivers, exemptions, agreements, or legislation to allow all current state payments for health care to be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the authority shall seek from the legislature a contribution for health care services that may not decrease in relation to state government expenditures for health care services in 1995, corrected for changes in the state gross domestic product and population.

(2) The authority may transfer funding for state programs for health services to the health security system.

NEW SECTION. **Section 80. County and local contributions to health security fund.** The authority shall seek all necessary waivers, exemptions, agreements, or legislation to allow all current county or other local agency payments for health care, including employee health benefits and health benefits for retired employees, to be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by counties or other local agencies or local governments with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the authority shall seek contributions for health care services that may not decrease in relation to expenditures for health care services in 1995, corrected for changes in the state gross domestic product and population.

NEW SECTION. **Section 81. Health security system responsibility.** The health security system's responsibility for providing care is secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for those programs is not transferred to the health security fund or that the transfer is delayed beyond the date on which initial benefits are provided under the health security system.

NEW SECTION. **Section 82. Federal, state, local contributions.** In order to diminish the administrative burden of maintaining eligibility records for programs transferred to the health security system, the authority shall strive to reach an agreement with federal, state, and local governments in which their contributions to the health security fund must be fixed to the rate of change of the state gross domestic product and population.

NEW SECTION. **Section 83. Health security fund personal income tax.** (1) All heads of households and persons subject to Montana income tax shall pay a health security income tax commencing January 1 of [the second year following the effective date of this act].

(2) The tax rate is 10% of taxable income as defined in 15-30-102 but not less than $50 per household per year.

(3) In the case of households in which no member files a Montana income tax return, the authority shall establish mechanisms or coordinate with other state agencies to establish mechanisms for the collection of the minimum tax, including but not limited to deduction of the tax from transfer payments or entitlements at their source.

(4) The revenue collected by this tax must be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 84. Credit against individual health security income tax.** (1) Individuals must receive a credit against their individual health security income tax obligation for either or both of the following:

(a) any credit arising under [section 89(2)];

(b) any premium or tax paid by the individual required by federal health care reform legislation to the extent that the payments are mandatory and an election is not allowed for a single payor system.

(2) In no case may the amount of a credit provided under this section exceed the individual's health security income tax obligation in any year. A credit may not be carried over from year to year.

NEW SECTION. **Section 85. Employer option.** (1) [Sections 1 through 82, 101, 104, and 105] may not be construed to interfere with an employer choosing to pay, in part or in full, the individual health security income tax for an employee.

(2) If an employer chooses to pay the health security income tax on behalf of an employee, the payments may not substitute for any obligation of the employer pursuant to [section 86].

NEW SECTION. **Section 86. Employer health security system fund payroll tax.** (1) (a) There is imposed on each employer a health security fund payroll tax in an amount equal to 7.3% of the employer's payroll in the preceding calendar quarter, except that if an employer is subject to 15-30-204(2), the tax is an amount equal to 7.3% of the employer's payroll in the preceding week.

(b) For the tax years beginning after [the effective date of this act] there is imposed a health security fund tax equal to 7.3% on the profit of each separate business of a sole proprietor and on the distributive share of ordinary income of each subchapter S. corporation shareholder, partner of a partnership, or member or manager of a limited liability company.

(c) A corporate officer of a subchapter S. corporation who receives wages as an employee of the corporation shall pay the health security fund tax on both the wages and any distributive share of ordinary income at the employee rate. The subchapter S. corporation is not liable for the tax on the corporate officer's wages.

(d) A corporate officer of a closely held corporation that meets the stock ownership test under section 542(a)(2) of the Internal Revenue Code and receives wages as an employee of the corporation is required to pay the health security tax only on the wages received. The corporation is not liable for the tax on the corporate officer's wages.

(e) Each employer shall maintain the records that the department requires concerning the health security fund payroll tax. The records are subject to inspection by the department and its employees and agents during regular business hours.

(f) An employee does not have any right of action against an employer for any money deducted and withheld from an employee's wages and paid to the state in compliance or intended compliance with

this section.

(g) The employer is liable to the state for any amount of health security fund payroll taxes, plus interest and penalty, when the employer fails to withhold from an employee's wages or fails to remit to the state the health security fund payroll tax required by this section.

(h) A sole proprietor, subchapter S. corporation shareholder, partner of a partnership, or member or manager of a limited liability company is liable to the state for the health security fund payroll tax, plus interest and penalty, when the sole proprietor, shareholder, partner, member, or manager fails to remit to the state the health security fund payroll tax required by this section.

(2) All collections of the tax must be deposited in the health security fund. The tax is in addition to any other tax or fee assessed against persons subject to the tax.

(3) (a) On or before the last day of April, July, October, and January, each employer subject to the tax shall file a return in the form and containing the information required by the department and, except as provided in subsection (3)(b), pay the amount of tax required by this section to be paid on the employer's payroll for the preceding calendar quarter.

(b) An employer subject to 15-30-204(2) shall remit to the department a weekly payment with its weekly withholding tax payment in the amount required by subsection (1).

(c) Tax payments required by subsection (1) must be made with the return filed pursuant to 15-30-204. The department shall first credit a payment to the liability under 15-30-202 and credit any remainder to the health security fund account provided in [section 76].

(d) Tax payments due from sole proprietors, subchapter S. corporation shareholders, partners of partnerships, and members or managers of limited liability companies must be made with and at the same time as the returns filed pursuant to 15-30-144 and 15-30-241. The department shall first credit a payment to the liability under 15-30-103 or 15-30-202 and shall then credit any remainder to the health security fund account provided in [section 76].

(4) An employer's officer or employee with the duty to collect, account for, and pay to the department the amounts due under this section who fails to pay an amount is liable to the state for the unpaid amount and any penalty and interest relating to that amount.

(5) Returns and remittances under subsection (3) and any information obtained by the department during an audit are subject to the provisions of 15-30-303, but the department may disclose the information to the authority under circumstances and conditions that ensure the continued confidentiality of the

information.

(6) The provisions of Title 15, chapter 30, that are not in conflict with the provisions of this part regarding administration, remedies, enforcement, collections, hearings, interest, deficiency assessments, credits for overpayment, statute of limitations, penalties, estimated taxes, and department rulemaking authority apply to the tax, to employers, to employees, to sole proprietors, to subchapter S. corporation shareholders, to partners of partnerships, to members or managers of limited liability companies, and to the department.

(7) The authority shall seek approval from the federal government to include federal employees in the payroll tax base.

(8) [Sections 1 through 82, 101, 104, and 105] may not be construed to prevent an employer from providing health benefits in excess of those available under the health security system.

(9) The authority and the department may seek assistance from any appropriate state agency in obtaining the data necessary to carry out this section.

NEW SECTION. **Section 87. Exempt employers.** (1) An employer is exempt from the payroll tax requirements of [sections 86, 88, and 89] if it has established an employee benefit plan subject to federal law that preempts the funding provisions of [sections 20 through 30, 75(3) through 81, 83, 86, 87, 91, and 92].

(2) Notwithstanding the provisions of subsection (1), an exempt employer shall comply with the reporting requirements of [section 86(3)] to the extent permitted by federal law.

(3) An employer is exempt from any other provisions of [sections 1 through 82, 101, 104, and 105] to the extent compliance with the provision would be preempted by federal law. It is the intent of the legislature that the provisions of [sections 1 through 82, 101, 104, and 105] be construed to be consistent with federal law.

NEW SECTION. **Section 88. Phasein of employer health security fund payroll tax.** (1) For the first year in which benefits are provided under [sections 1 through 82, 101, 104, and 105], the payroll tax rate is the amount specified in [section 86], adjusted as follows:

(a) by adding, in the case of an employer whose base year health insurance and benefit payments, expressed as a percentage of payroll, was greater than the rate specified in [section 86], two-thirds of the

difference between these two rates;

(b) by subtracting, in the case of an employer whose base year health insurance and benefit payments, expressed as a percentage of payroll, was less than the rate specified in [section 86], two-thirds of the difference between these two rates.

(2) For the second year in which benefits are provided under the health security system, the payroll tax rates must equal the amount calculated in subsection (1), replacing the fraction two-thirds in subsections (1)(a) and (1)(b) with the fraction one-third.

NEW SECTION. **Section 89. Credit against employer health security fund payroll tax.** (1) With respect to each employee affected, an employer who on [the effective date of this act] was under a contractual or legal obligation to provide the employee with health care benefits, which are covered benefits under the health security system, or to pay for benefits through a policy of insurance or otherwise, must receive a credit against its payroll tax obligation in a tax period equal to the amount it pays during that period for the benefits or insurance pursuant to the contract or legal obligation.

(2) Entitlement to the credit lapses upon the expiration of the contractual or legal obligation. A credit may not be claimed for any obligation arising on or after [the effective date of this act].

(3) Subsection (1) may not apply to obligations subject to federal preemption as described in [sections 21, 75(3), and 87].

(4) (a) In the event that the amount of a credit provided by this section exceeds the employer's payroll tax obligation for any affected employee, the excess must be credited against the employee's tax obligation imposed by [section 83].

(b) In the case of an employer that is exempt from the payroll tax obligation pursuant to [section 87], the amount of credit to be applied to the employee's tax obligation must be determined in the same manner as in the case of a nonexempt employer.

(5) A credit may not be carried over from year to year or transferred among employees.

NEW SECTION. **Section 90. Corporate income health security fund surtax.** After the amount of tax liability has been computed under 15-31-121(1) through (3), each corporation subject to taxation under Title 15, chapter 31, part 1, shall add a health security fund surtax of 6 3/4%. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account

established in [section 76].

NEW SECTION. **Section 91. Health security fund cigarette tax.** There is imposed a health security fund tax, in addition to the tax imposed in 16-11-111, of 18 cents on each package containing 20 cigarettes, and when packages contain more or less than 20 cigarettes, a tax on each cigarette equal to 1/20th the tax on a package containing 20 cigarettes is imposed. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76]. The tax in this section is subject to 16-11-111(2) through (6).

NEW SECTION. **Section 92. Health security fund tobacco products tax.** There is imposed a health security fund tax, in addition to the tax in 16-11-202, of 12 1/2% of the wholesale price of tobacco products other than cigarettes sold or possessed in this state, excepting from the tax tobacco products shipped from Montana and destined for retail sale and consumption outside the state. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 93. Health security fund tax on beer.** In addition to the taxes levied in 16-1-406 and 16-1-408, a tax of $4.30 per barrel of 31 gallons is levied and imposed on each barrel of beer sold in Montana by any wholesaler. The tax is due at the end of each month from a wholesaler on beer sold during that month. Any beer that is sold in containers other than in barrels or in barrels of more or less capacity than 31 gallons, the quantity content must be computed by the department in determining the amount due. Revenues from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 94. Liquor health security fund tax.** In addition to the excise tax provided for in 16-1-401 and the license tax provided for in 16-1-404, the department shall collect at the time of sale and delivery of any liquor under any provisions of the laws of the state a health security fund tax of 16% of the retail selling price on all liquor sold and delivered in the state. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 95. Health security fund tax on table wine.** (1) In addition to the tax levied in 16-1-411, a health security fund tax of 27 cents per liter is imposed on table wine imported by a table wine distributor or the department.

(2) (a) The tax on table wine imported by a table wine distributor must be paid by the table wine distributor by the 15th day of the month following sale of the table wine from the table wine distributor's warehouse. Failure to file a table wine tax return or failure to pay the tax required by this section subjects the table wine distributor to the penalties and interest provided for in 16-1-409.

(b) The tax on table wine imported by the department must be collected at the time of sale.

(3) Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 96. Coal health security fund tax.** (1) In addition to the tax provided for in 15-35-103, a health security fund tax is imposed on each ton of coal produced in the state according to the following schedule:

Surface mining	10% of value
Underground mining	3% of value
Extended depth auger mining	7.5% of value

(2) Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 97. Oil and gas health security fund tax.** In addition to the tax provided for in 15-36-101, each person engaging in or carrying on the business of producing petroleum, other mineral or crude oil, or natural gas within this state or engaging in or carrying on the business of owning, controlling, managing, leasing, or operating within this state any well or wells from which any merchantable or marketable petroleum, other mineral or crude oil, or natural gas is extracted or produced shall, except as provided in 15-36-121, for each year when engaged in or carrying on the business in this state pay to the department of revenue for deposit, in accordance with 15-1-501(6), in the health security fund provided in [section 76] a health security fund tax of 5% on the gross taxable value of all the petroleum, other mineral or crude oil, or natural gas produced by the person.

NEW SECTION. **Section 98. Metalliferous mines health security fund tax.** In addition to the tax provided for in 15-37-103, the annual health security fund tax to be paid by a person engaged in or carrying on the business of working or operating any mine or mining property in the state from which gold, silver, copper, lead, or any other metal or metals or precious or semiprecious gems or stones are produced is 1.85% computed on the gross value of product that may have been derived by the person from the mining business, work, or operation within this state during the calendar year immediately preceding.

NEW SECTION. **Section 99. Health security fund gambling machine licensing tax.** There is imposed upon each licensed operator who is issued a permit under this part a health security fund tax of 15% of the gross income from each video gambling machine licensed under this part. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 100. Health security fund accommodations tax.** In addition to the tax provided in 15-65-111, a health security fund tax, is imposed at a rate equal to 4% of the accommodation charge collected by the facility. Revenue from this section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account established in [section 76].

NEW SECTION. **Section 101. Legislative amendment.** (1) The provisions of [sections 1 through 82, 101, 104, and 105] may not be amended except to further its purposes by a statute passed by a vote of two-thirds of each house or upon approval by the electorate.

(2) The two-thirds vote requirement of subsection (1) does not apply to any provision of [sections 1 through 82, 101, 104, and 105] that meets any of the following requirements:

(a) the provision specifically mentions and authorizes action by the legislature, in which case a majority of the membership in each house is sufficient for amendment;

(b) the provision specifically states a different method for amendment, in which case that method controls;

(c) the provision must be amended to achieve compliance with federal health care reform legislation, pursuant to [sections 74 and 75], in which case a majority of the membership in each house is sufficient for amendment.

Section 102. Section 15-1-501, MCA, is amended to read:

"**15-1-501. Disposition of money from certain designated license and other taxes.** (1) The state treasurer shall deposit to the credit of the state general fund in accordance with the provisions of subsection (6) all money received from the collection of:

(a) fees from driver's licenses, motorcycle endorsements, and duplicate driver's licenses as provided in 61-5-121;

(b) electrical energy producer's license taxes under chapter 51;

(c) severance taxes allocated to the general fund under chapter 36;

(d) liquor license taxes under Title 16, except those imposed under [sections 93 through 95];

(e) telephone company license taxes under chapter 53; and

(f) inheritance and estate taxes under Title 72, chapter 16.

(2) ~~All~~ Except for the money received from [sections 83 and 86], all money received from the collection of income taxes under chapter 30 of this title must, in accordance with the provisions of subsection (6), be deposited as follows:

(a) 91.3% of the taxes to the credit of the state general fund;

(b) 8.7% of the taxes to the credit of the debt service account for long-range building program bonds as described in 17-5-408; and

(c) all interest and penalties to the credit of the state general fund.

(3) ~~All~~ Except for the money received from [section 90], all money received from the collection of corporation license and income taxes under chapter 31 of this title, except as provided in 15-31-702, must, in accordance with the provisions of subsection (6), be deposited as follows:

(a) 89.5% of the taxes to the credit of the state general fund;

(b) 10.5% of the taxes to the credit of the debt service account for long-range building program bonds as described in 17-5-408; and

(c) all interest and penalties to the credit of the state general fund.

(4) The department of revenue shall also deposit to the credit of the state general fund all money received from the collection of license taxes, fees, and all net revenues and receipts from all other sources under the operation of the Montana Alcoholic Beverage Code.

(5) After the distribution provided for in 15-36-112 and [section 97], the remainder of the oil severance tax collections must be deposited in the general fund.

(6) Notwithstanding any other provision of law, the distribution of tax revenue must be made according to the provisions of the law governing allocation of the tax that were in effect for the period in which the tax revenue was recorded for accounting purposes. Tax revenue must be recorded as prescribed by the department of administration, pursuant to 17-1-102(2) and (5), in accordance with generally accepted accounting principles.

(7) All refunds of taxes must be attributed to the funds in which the taxes are currently being recorded. All refunds of interest and penalties must be attributed to the funds in which the interest and penalties are currently being recorded."

Section 103. Section 17-5-408, MCA, is amended to read:

"**17-5-408. Percentage of income, corporation license, and cigarette tax pledged.** (1) (a) The state pledges and appropriates and directs to be credited as received to the debt service account, except as provided in [section 83], money received from the collection of the individual income tax and, except as provided in 15-31-702 and [section 90], money received from the collection of the corporation license and income tax, as provided in 15-1-501, as may at any time be needed to comply with the principal and interest and reserve requirements stated in 17-5-405(4).

(b) The pledge and appropriation made by this section are a first and prior charge upon all money received from the collection of the enumerated taxes.

(2) Except for the amount credited to the veterans' home maintenance and improvement account under 16-11-119 and [sections 91 and 92], the state pledges and appropriates and directs to be credited to the debt service account 79.75% of all remaining money received from the collection of the excise tax on cigarettes that is levied, imposed, and assessed by 16-11-111. The state also pledges and appropriates and directs to be credited as received to the debt service account, except as provided in [section 92], all money received from the collection of the taxes on other tobacco products that are or may be imposed for that purpose, including the tax imposed by 16-11-202. This section does not impair or otherwise affect the provisions and covenants contained in the resolutions authorizing the presently outstanding long-range building program bonds. Subject to the provisions of the preceding sentence, the pledge and appropriation made by this section are a first and prior charge upon all money received from the collection of all taxes referred to in this subsection."

NEW SECTION. **Section 104. Insurance provisions not applicable.** The provisions of Title 33 do not apply to [sections 1 through 82, 101, 104, and 105].

NEW SECTION. **Section 105. Construction.** [This act] must be construed as necessary to comply with federal health care legislation, consistent with the intent of the act to establish a single payor for health care with freedom of choice of professional provider and a single standard of care for all Montanans eligible for particular services under the health security system.

NEW SECTION. **Section 106. Codification instruction.** (1) [Sections 1 through 82, 101, 104, and 105] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through 82, 101, 104, and 105].

(2) [Sections 83 through 89] are intended to be codified as an integral part of Title 15, chapter 30, and the provisions of Title 15, chapter 30, apply to [sections 83 through 89].

(3) [Section 90] is intended to be codified as an integral part of Title 15, chapter 31, part 1, and the provisions of Title 15, chapter 31, part 1, apply to [section 90].

(4) [Section 91] is intended to be codified as an integral part of Title 16, chapter 11, part 1, and the provisions of Title 16, chapter 11, part 1, apply to [section 91].

(5) [Section 92] is intended to be codified as an integral part of Title 16, chapter 11, part 2, and the provisions of Title 16, chapter 11, part 2, apply to [section 92].

(6) [Sections 93 through 95] are intended to be codified as an integral part of Title 16, chapter 1, part 4, and the provisions of Title 16, chapter 1, part 4, apply to [sections 93 through 95].

(7) [Section 96] is intended to be codified as an integral part of Title 15, chapter 35, part 1, and the provisions of Title 15, chapter 35, part 1, apply to [section 96].

(8) [Section 97] is intended to be codified as an integral part of Title 15, chapter 36, part 1, and the provisions of Title 15, chapter 36, part 1, apply to [section 97].

(9) [Section 98] is intended to be codified as an integral part of Title 15, chapter 37, part 1, and the provisions of Title 15, chapter 37, part 1, apply to [section 98].

(10) [Section 99] is intended to be codified as an integral part of Title 23, chapter 5, part 6, and the provisions of Title 23, chapter 5, part 6, apply to [section 99].

(11) [Section 100] is intended to be codified as an integral part of Title 15, chapter 65, part 1, and

the provisions of Title 15, chapter 65, part 1, apply to [section 100].

NEW SECTION. **Section 107. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0548, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

An act providing for the Montana Health Security System; creating an integrated payment mechanism for health care; setting eligibility requirements; authorizing the Montana Health Care Authority to define the benefits; outlining the health care authority's duties and powers; providing for public hearings, monitoring and evaluation; providing for exempt employers and employees; providing for collection from collateral sources; providing for budgets and expenditure limits for the health security system; providing for choices in forms of provider reimbursement and payment mechanisms; providing for provider representation in negotiations; allowing integrated delivery systems; providing for capital expenditures; providing for cost control measures; providing enforcement mechanisms; providing for a phase-in of the health security system; providing for hearings and judicial review; providing for practice outside of the health security system; providing for open participation; providing for coordination with other laws; providing for compliance with federal legislation; providing for the health care authority to apply for necessary federal waivers; creating a health security fund and reserve account; providing for appropriations by the legislature; providing funding provisions; creating a health security fund personal income tax and credit; creating an employer health security system payroll tax, phase-in, option, and credit; creating a corporate health security fund income tax; creating a health security fund cigarette tax; creating a health security fund tobacco products tax; creating a health security fund gambling machine licensing tax; creating a health security fund accommodations tax; providing for two-thirds vote for certain future legislative amendments.

ASSUMPTIONS:

1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation.
2. This act will provide health care coverage for all Montana residents.
3. The cost of the single-payer system statewide is expected to be $2,587,800,000 in FY96, and $2,736,600,000 in FY97, based on an estimated growth rate of 5.75% annually. This is from the Montana Health Care Authority Statewide Universal Health Care Access Plans document. However, this figure does not include coverage for all residents of Montana, since it does not include coverage of individuals in programs such as Medicare, Indian Health Service, Veterans Affairs, military health care, and CHAMPUS, or those covered under ERISA plans. (Please see assumptions eight and nine below.)
4. All funds for state programs such as Medicaid, Managing Resources Montana, and health care coverage provided through the Department of Corrections and Human Services will be transferred to the single-payer plan. The populations previously served then will be covered by the single-payer plan.
5. The Medicaid program in Montana will be discontinued since this population will be covered under the single-payer system. For purposes of this fiscal note, assume that the federal government will grant all waivers to allow the state to cover this population (including long-term care benefits) under the single-payer plan benefits package in lieu of the Medicaid benefits (which are more extensive). (To date, the federal government has not approved any waivers which reduce benefits to Medicaid

(continued)

Dave Lewis 2-20-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

BILL CAREY, PRIMARY SPONSOR DATE

eligibles. If the federal waiver were not approved, Montana would likely have to provide a supplemental package of benefits to Medicaid eligibles, at a minimum. Such costs are not included within the scope of this fiscal note.) The federal government also will continue to provide federal funds, at the FY94 level, to offset a portion of the costs of the Medicaid eligible population.

6. The bill does not explicitly outline the infrastructure for administering the single-payer plan. For purposes of this fiscal note, assume that staff currently administering the various state-run health care programs (e.g., Medicaid, MRM) and the state employee health plans will administer the single-payer plan under the direction of the Montana Health Care Authority. The authority assumes it will need 9.00 FTE and related costs, in addition to the present law 3.00 FTE, to administer the single-payer plan.
7. All state employees and retirees will be covered under the single-payer plan in lieu of receiving their coverage through the existing health plans. The funds for the existing state employees and retirees health plans will be saved, and the payroll tax assessment on employees will be used to pay for the coverage for these groups under the single-payer plan.
8. The state will receive an ERISA waiver from the federal government.
9. The state will receive waivers from Medicare, Indian Health Service, Veterans Affairs, military health care, and CHAMPUS to allow coverage of these populations. The federal funds from these plans will be available to partially fund the single-payer plan.
10. The effective date of this bill is January 1, 1996. The sole proprietor payroll health security system fund tax would be effective January 1, 1997. The individual income health security system fund tax would be effective January 1, 1998. All other health security system fund taxes under this proposal would become effective January 1, 1996.
11. All collections for health security fund taxes will begin as soon as they become effective (i.e., no lag time).
12. Revenues are based on no exemptions and no credits.
13. The health security fund personal income tax imposed under this bill is 10% of taxable income from full year residents with a minimum tax of $50 per household. This is not effective until January 1, 1998, and therefore would have no impact on revenue in FY96 or FY97. Full year revenue from this source would be approximately $659 million.
14. The health security fund payroll tax imposed under this bill is 7.3% of an employer's payroll in the preceding calendar quarter, or 7.3% of the employer's payroll in the preceding week. This would increase revenue by $265.496 million in FY96 and $554.013 million in FY97.
15. The health security fund payroll tax imposed under this bill is 7.3% of the profit of each business of a sole proprietor and on the share of ordinary income of each subchapter S corporation shareholder, partner of a partnership, or member of a limited liability company. This tax is effective January 1, 1997, and would have no impact on revenue in FY96, but would increase revenue by $82.125 million in FY97. Full year revenue from this source would be approximately $164.250 million.
16. The health security fund cigarette tax imposed under this bill is 18 cents per pack and is effective January 1, 1996. This tax would increase revenue by $6.027 million in FY96 and would increase revenue by $11.962 million in FY97.
17. The health security fund tobacco products tax imposed under this bill is 12.5% of the wholesale price of tobacco products and is effective January 1, 1996. This tax would increase revenue by $.769 million in FY96 and would increase revenue by $1.653 million in FY97.
18. The health security fund beer tax imposed under this bill is $4.30 per barrel of 31 gallons and is effective January 1, 1996. This tax would increase revenue by $1.662 million in FY96 and would increase revenue by $3.324 million in FY97.

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19. The health security fund liquor tax imposed under this bill is 16% of the retail selling price and is effective January 1, 1996. This tax would increase revenue by $3.180 million in FY96 and would increase revenue by $6.452 million in FY97.
20. The health security fund table wine tax imposed under this bill is 27 cents per liter and is effective January 1, 1996. This tax would increase revenue by $.596 million in FY96 and would increase revenue by $1.150 million in FY97.
21. The health security fund coal tax imposed under this bill is 10% of value for surface mining; 3% of value for underground mining; and 7.5% of extended depth auger mining and is effective January 1, 1996. This tax would increase revenue by $14.952 million in FY96 and would increase revenue by $28.239 million in FY97.
22. The health security fund oil and gas tax imposed under this bill is 5% of the gross value of all petroleum, mineral or crude oil, and natural gas and is effective January 1, 1996. These taxes would increase revenue by $6.625 million in FY96 and would increase revenue by $13.518 million in FY97.
23. The health security fund metalliferous mines tax imposed under this bill is 1.85% of the gross value and is effective January 1, 1996. This tax would increase revenue by $3.021 million in FY96 and would increase revenue by $5.698 million in FY97.
24. The health security fund video gambling machine tax imposed under this bill is 15% of the gross income from each machine and is effective January 1, 1996. This tax would increase revenue by $18.009 million in FY96 and would increase revenue by $39.468 million in FY97.
25. The health security fund accommodations tax imposed under this bill is 4% of the accommodation charge and is effective January 1, 1996. This tax would increase revenue by $4.265 million in FY96 and would increase revenue by $8.830 million in FY97.
26. When all health security fund taxes are fully implemented the total impact will be $1.6 billion per annum. There are two taxes which would not be fully implemented in FY97. The payroll tax for self-employed is not effective until January 1, 1997, and, therefore, the figure of $82.125 million represents only half the revenue that would be collected from this source in a full fiscal year. The health security fund individual income tax is not effective until January 1, 1998, thus having no impact on revenue for FY96 or FY97. Revenue from this source would be approximately $659 million annually when this tax is fully implemented.
27. No funds are included for start up of the single-payer plan. The bill includes a provision for the legislature to fund start up costs to implement the plan. However, at this time, without figuring in the cost of groups (listed in assumptions eight and nine above, for which the state will need federal waivers in order to cover under the single-payer plan), the start up costs cannot be determined. The cost would likely be several million dollars general fund.

FISCAL IMPACT:

Expenditures:	FY96 Difference	FY97 Difference
FTE	9.00	9.00
Personal Services (MHCA)	293,197	293,197
Operating (MHCA)	450,000	450,000
Equipment (MHCA)	120,000	30,000
Employer Payroll Tax	31,552,572	31,881,166
State Employee/Retiree Health Insurance	(31,354,725)	(31,169,529)
Total	1,061,044	1,484,834
Funding:		
General Fund	962,120	1,129,015
Other Funds	98,924	355,819
Total	1,061,044	1,484,834

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Revenues:

Net Impact:		
Individual Income Tax	0	0
Payroll Tax	300,927,000	618,266,000
Payroll-Self Employed	0	82,125,000
Corporate Income Tax	39,570,000	83,769,000
Cigarette Tax	6,027,000	11,962,000
Tobacco Products Tax	769,000	1,653,000
Beer Tax	1,662,000	3,324,000
Liquor Tax	3,180,000	6,452,000
Table Wine Tax,	596,000	1,150,000
Coal Tax	14,952,000	28,239,000
Oil and Natural Gas Tax	6,625,000	13,518,000
Metalliferous Mines Tax	3,021,000	5,698,000
Gambling Machine Tax	18,009,000	39,468,000
Accommodations Tax	4,265,000	8,830,000
Total	399,603,000	904,454,000

Total Net Impact on General Fund Balance:		
General Fund (Cost) (01)	(962,120)	(1,129,015)

TECHNICAL NOTE:
There is a question as to whether the 6.75% corporation income surtax refers to tax liability or taxable income. For the purposes of this note the health security fund corporate income tax was based on 6.75% of taxable income.