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Carry House BILL NO. 503

INTRODUCED BY _____

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 DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO DEFINE THE BENEFITS; OUTLINING THE DEPARTMENT'S DUTIES AND POWERS; PROVIDING FOR TRANSFER OF STATE PROGRAMS UPON STUDY BY THE DEPARTMENT; 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 DEPARTMENT TO APPLY FOR NECESSARY FEDERAL WAIVERS; CREATING HEALTH SECURITY FUND TAXES ON PERSONAL INCOME, EMPLOYER PAYROLL, CORPORATE INCOME, CIGARETTES, TOBACCO PRODUCTS, BEER, LIQUOR, TABLE WINES, COAL PRODUCTION, OIL AND GAS PRODUCTION, METALLIFEROUS MINE PRODUCTION, GAMBLING MACHINE LICENSING, AND ACCOMMODATIONS; CREATING A HEALTH SECURITY FUND PERSONAL INCOME TAX CREDIT; CREATING A HEALTH SECURITY SYSTEM PAYROLL TAX PHASEIN, OPTION, AND CREDIT; PROVIDING FOR A 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 department of public health and human services rulemaking authority to adopt standards and criteria by rule for primary care; medical specialists; prescription drugs; allocation of operating funds; provider and facility reimbursement;

1 termination of participation; urban and rural facilities; primary, secondary, and tertiary care; public health;
2 financial criteria and disclosure by providers for interest in facilities; and utilization.

3 It is the intent of the legislature that the rules:

- 4 (1) address the process of establishing and maintaining a statewide health security system;
- 5 (2) develop an integrated payment mechanism for health care;
- 6 (3) provide coverage for all eligible persons in Montana;
- 7 (4) establish a comprehensive benefits package to which all eligible persons have access;
- 8 (5) establish a process for cost containment; and
- 9 (6) provide an equitable and broad-based funding system.

10

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

12

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

15

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

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

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

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

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

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

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

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

28 (8) A lack of consistent and timely data about the costs, use, and quality of Montana's health care
29 system means that providers and consumers alike cannot obtain relevant and up-to-date information
30 regarding the efficiency and effectiveness of services.

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

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

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

- 10 (a) maintain and improve the quality of health care services offered to Montanans;
11 (b) contain or reduce increases in the cost of delivering services so that health care costs do not
12 consume a disproportionate share of Montanans' income;
13 (c) avoid unnecessary duplication in the development of health care facilities and services;
14 (d) encourage regional and local participation in decisions about health care delivery, financing, and
15 provider supply;
16 (e) promote the rational allocation of health resources in the state;
17 (f) facilitate universal access to preventive, primary, and other medically necessary health care; and
18 (g) educate consumers about the proper use of the health care system and about the importance
19 of individuals assuming greater responsibility for their own health status by improving their health-related
20 behavior.

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

- 22 (a) operate as efficiently and effectively as possible, with the administrative aspects of the system
23 made as simple and "user friendly" as possible; and
24 (b) provide accurate and accessible information that will enable consumers and providers to make
25 more informed decisions and that will provide better measures of the performance of the health care
26 delivery system, including patient outcomes.

27 (5) In reforming the health care system to achieve these objectives, the state shall ensure that any
28 negative impacts of its reform policies on other aspects of the state's economy, particularly on small
29 businesses, are minimized.

30

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

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

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

8 (3) "Department" means the department of public health and human services provided for in Title
9 2, chapter 15, part 22.

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

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

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

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

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

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

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

27 (10) "Medical indication" means the set of medical conditions for which there is evidence that a
28 particular service improves the overall health outcome of patients receiving that service.

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

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

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

6 (a) a fee for each service provided;

7 (b) capitation;

8 (c) salary.

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

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

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

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

16 (18) "Resident" means a person who fulfills residence requirements as described in 1-1-215 or as
17 otherwise defined by statute.

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

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

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

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

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

27 (22) "System" means the health security system established by [sections 1 through 82, 101, 104,
28 and 105].

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

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

3

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

7

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

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

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

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

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

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

24

25 **NEW SECTION. Section 7. Presumptive eligibility.** (1) Upon arrival at a health care facility, if a
26 person is unconscious, comatose, or otherwise unable because of the person's physical or mental condition
27 to document eligibility or to act in the person's own behalf or if the person is a minor, the person is
28 presumed to be eligible and the health care facility shall provide care as if the person were eligible.

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

1 commitment is presumed eligible.

2

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

5

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

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

11 (a) as authorized by the department under provisions for implementing the phasein of the health
12 security system, as provided in [sections 64 through 67]; or

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

14

15 **NEW SECTION. Section 10. Medical benefits.** (1) The department shall, by January 1, 1998,
16 adopt rules to implement a medical benefit package.

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

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

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

23 (3) The department shall consider including long-term care benefits in the health security system.
24 The recommendations to the public and to the legislature must contain recommendations regarding
25 long-term care benefits.

26

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

30 (2) Coverage for any service or benefit not previously covered by the health security system may

1 be instituted without expansion of benefits if the department determines it is of equivalent therapeutic value
2 or is a less costly treatment alternative to a listed service and if the service or benefit is provided by a
3 professional provider acting within the scope of the professional provider's practice.

4
5 **NEW SECTION. Section 12. Exclusion of benefits.** (1) Services determined to have no medical
6 indication by the department must be excluded from coverage under the health security system.

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

9
10 **NEW SECTION. Section 13. Coverage for Montanans while out of state.** (1) The health security
11 system shall cover all eligible Montana residents traveling out of the state for up to 90 days in each
12 12-month period.

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

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

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

20
21 **NEW SECTION. Section 14. Emergency benefits.** Emergency care and health care services
22 necessary to safeguard the health of the population must be readily available through the health security
23 system to all individuals.

24
25 **NEW SECTION. Section 15. Department health security system powers and duties.** (1) The
26 department's powers include all powers necessary and proper to implement [sections 1 through 82, 101,
27 104, and 105] and to promote its underlying aims and purposes. These broad powers include but are not
28 limited to the power to set rates and adopt rules on all matters relating to the implementation of [sections
29 1 through 82, 101, 104, and 105].

30 (2) The department shall establish and maintain a system of universal access to medical care for

- 1 all Montanans including the following:
- 2 (a) implement statutory eligibility standards;
- 3 (b) adopt annually a benefits package for consumers;
- 4 (c) act directly or through one or more contractors as the single payor for all claims for services
5 provided under [sections 32 through 38];
- 6 (d) develop and implement separate formulas for determining budgets pursuant to [sections 32
7 through 38];
- 8 (e) review the formulas described in subsection (2)(d) annually for appropriateness and sufficiency
9 of rates, fees, and prices;
- 10 (f) provide for timely payments to professional providers and health care facilities through a
11 structure that is efficient to administer and that eliminates unnecessary administrative costs. The cost of
12 administration of the health security system may not exceed the limits set in [sections 32 through 38].
- 13 (g) implement, to the extent permitted by federal law, standardized claims and reporting methods;
- 14 (h) establish an enrollment system that will ensure that all eligible Montanans, including those who
15 travel frequently, those who cannot read, and those who do not speak English, are aware of their right to
16 health care and are formally enrolled;
- 17 (i) determine the number and precise county-by-county composition of the system regions, based
18 on criteria of common economic and demographic features and geographic contiguity;
- 19 (j) bid for prescription drug contracts in order to achieve the lowest possible cost for drugs available
20 under the system;
- 21 (k) negotiate for or set rates, fees, and prices involving any aspect of the health security system
22 and establish procedures relating to rates, fees, and prices;
- 23 (l) administer the revenue of the health security system in accordance with [sections 78 through
24 82];
- 25 (m) procure funds (including loans), lease or purchase property, and obtain appropriate liability and
26 other forms of insurance for the health security system and its employees and agents;
- 27 (n) establish, appoint, and fund, as part of the administration of the health security system, the
28 regional health care planning boards;
- 29 (o) administer all aspects of the health security system that include but are not limited to the
30 following:

- 1 (i) establish standards and criteria by rule for allocation of operating funds;
- 2 (ii) meet regularly with the regional health care planning boards to review the impact of the health
3 security system and its policies on the regions;
- 4 (iii) budget to most equitably meet the health care needs of the population of the state as a whole
5 and the population within each region pursuant to the specific purposes that have been established;
- 6 (iv) achieve the best pharmaceutical drug prices for the health security system; and
- 7 (p) gather and analyze data necessary for the efficient and equitable functioning of the health
8 security system pursuant to 50-4-502;
- 9 (3) In addition to all other powers conferred under [sections 1 through 82, 101, 104, and 105],
10 the department may:
- 11 (a) employ appropriate staff as necessary to implement [sections 1 through 82, 101, 104, and
12 105];
- 13 (b) delegate to appointed staff any aspect of the health security system that is the responsibility
14 of the department. Individuals employed by the department or by any department or state agency that is
15 made a part of the health security system shall perform their duties as the department assigns them.
- 16 (c) employ and direct attorneys on staff or as outside counsel in the defense or implementation of
17 any provision of [sections 1 through 82, 101, 104, and 105];
- 18 (d) sue and be sued to enforce any provision of [sections 1 through 82, 101, 104, and 105];
- 19 (e) seek, at the department's discretion, legal advice or counsel from the attorney general;
- 20 (f) incur travel expenses as are necessary for the performance of the department's duties;
- 21 (g) issue subpoenas, administer oaths, and examine under oath any person as to any matter
22 pertinent to the administration of the health security system;
- 23 (h) adopt rules for procedures and standards for competitive bidding that govern the contracts
24 authorized by this section. The provisions of Title 18 do not apply to the competitive bidding requirements;
25 and
- 26 (i) ensure that all existing statutes regarding confidentiality of medical records apply to the health
27 security system. A policy, directive, or study by the department may not be taken that compromises
28 confidentiality of medical records as established by law.

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30

NEW SECTION. Section 16. Transfer of state facilities -- programs. (1) [Sections 1 through 82,

1 101, 104, and 105] do not prevent the legislature from transferring to the health security system programs
2 for health care, including mental health care for patients in state hospitals and other health care facilities
3 owned by the state and facilities located in state prisons.

4 (2) Programs for individual clinical prevention and treatment administered by the department of
5 corrections and any other state or county entity that provides individual clinical prevention and treatment
6 services must be administered by the department to the extent that those programs are transferred to the
7 health security system.

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

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

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

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

- 22 (a) statewide planning and other programs of the department;
23 (b) institutional services provided by the department of corrections;
24 (c) medical assistance and medicaid from the department in the event of the receipt of federal
25 waivers; and
26 (d) the state employee medical benefit plan administered through the department of administration.

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

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

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

6 (3) This section does not apply to any rate, fee, or price that is negotiated with the department.
7

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

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

13 (2) the responsiveness of health care facilities in the region to the health care needs of the local
14 communities and populations they serve.
15

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

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

30 (3) Clinical data provided by individual professional providers must be confidential and used only

1 for statistical and systemwide purposes and for improving the quality of care.

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

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

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

13

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

17

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

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

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

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

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

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

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

6
7 **NEW SECTION. Section 22. Subrogation.** (1) It is the intent of the people to establish a single
8 public payor for all health care in the state of Montana. However, until the role of all other payers for
9 health care have been terminated, it is the intent of the people to recover health care costs from collateral
10 sources whenever medical services are provided to an individual that are or may be covered services under
11 a policy of insurance, health benefits plan, or other collateral source available to that individual or for which
12 the individual has a right of action for compensation to the extent permitted by law.

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

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

17 (b) health care and pension plans;

18 (c) employers;

19 (d) employee benefits contracts;

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

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

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

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

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

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

26 An entity described in subsection (2) is not excluded from the obligations imposed by [sections 21, 75, and
27 87] by virtue of a contract or relationship with a governmental unit, agency, or service.

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

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

6
7 **NEW SECTION. Section 24. Assignment from collateral source.** Use of an eligibility card for or
8 receipt of health care services under the health security system for which an individual is entitled to
9 coverage, reimbursement, indemnity, or other compensation from a collateral source is considered an
10 assignment by the individual to the health security system of the person's rights from or against the
11 collateral source to the extent of services provided under [sections 1 through 82, 101, 104, and 105]. Any
12 provision or agreement between the individual and the collateral source prohibiting assignment of rights is
13 not applicable to an assignment under this section. Except as specified in [sections 21, 75, and 87],
14 [sections 1 through 82, 101, 104, and 105] may not affect any person's right to benefits or money or right
15 of action from or against a collateral source.

16
17 **NEW SECTION. Section 25. Reimbursement from collateral source.** (1) The health security
18 system shall seek reimbursement from the collateral source for services provided to the individual and may
19 institute appropriate action, including suit, to recover reimbursement. Upon demand, the collateral source
20 shall pay to the health security fund any sums as it would have paid or expended on behalf of the individual
21 for the health care services provided by the health security system.

22 (2) In addition to any other right to recovery provided in [sections 21, 75, and 87], the department
23 has the same right to recover the reasonable value of benefits from a collateral source as provided in Title
24 53, chapters 2 and 4.

25
26 **NEW SECTION. Section 26. Collateral source services first.** If a collateral source is exempt from
27 subrogation or the obligation to reimburse the health security system as provided in [sections 22 and 87]
28 the department may require that an individual who is entitled to medical services from the source shall first
29 seek those services from that source.

30

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

6
7 **NEW SECTION. Section 28. Integration of workers' compensation.** In the event of integration of
8 workers' compensation health benefits into the health security system, the cost of workplace-related
9 medical claims that are found to result from unsafe workplace conditions or negligence on the part of the
10 employer must be borne by the employer rather than the health security system.

11
12 **NEW SECTION. Section 29. Revenue.** (1) Revenue to operate the health security system must
13 be generated in a manner intended to coincide in the aggregate with financial responsibility for health care
14 expenditures in the base year and may not exceed the limits described in [section 31].

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

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

24 (4) In the event of federal health care reform legislation including payroll, individual income, or
25 cigarette and tobacco products taxation, and to the extent that agreements are reached to transfer those
26 revenues into the health security fund, the legislature may enact a proportional decrease in the payroll,
27 individual income, and cigarette and tobacco taxes established pursuant to [sections 82 through 100] in
28 order that revenue to the health security fund will be maintained within the limits established by [sections
29 31(1) and 77(3)].

30

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

3
4 **NEW SECTION. Section 31. Expenditure limits.** (1) It is the intent of the legislature that
5 expenditures under the health security system not exceed in any year expenditures for the prior year
6 adjusted for changes in the state gross domestic product and population.

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

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

15
16 **NEW SECTION. Section 32. Preparation of budgets.** (1) The department shall prepare an annual
17 budget in the manner prescribed by law. The budget must include all of the following:

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

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

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

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

25 (2) The department shall prepare the system budget for the health security system to be submitted
26 to the legislature as part of the governor's budget.

27
28 **NEW SECTION. Section 33. System budget.** (1) The cost of the health security system, including
29 the cost of all services and benefits provided, administration, data gathering and other activities, and
30 revenue deposited pursuant to [section 76], comprise the system budget.

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

3
4 **NEW SECTION. Section 34. Regional budgets.** (1) The department, in consultation with the
5 regional health care planning boards, shall propose a regional budget for each system region.

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

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

13
14 **NEW SECTION. Section 35. Global budgets.** (1) The department, in consultation with the regional
15 health care planning boards, shall prepare a regional budget for each system region. That budget must
16 include allocations for each of the following:

17 (a) fee-for-service providers;

18 (b) capitated providers; and

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

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

25 (3) The global budget for fee-for-service providers in each system region must be further divided
26 among categories of professional providers, establishing a total annual budget for each category within each
27 region. Each of these category budgets must be sufficient to cover all included services anticipated to be
28 required by eligible individuals choosing fee-for-service within the region, at the rates negotiated or set by
29 the department, except as necessary for cost containment purposes under [sections 49 through 51].

30 (4) The global budget for capitated providers must be sufficient to cover all eligible individuals

1 choosing an integrated health delivery system within the system region, at the capitation rates negotiated
2 or set by the department, except as necessary for cost containment purposes under [sections 49 through
3 51].

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

8

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

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

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

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

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

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

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

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

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

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

26

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

1 allowing better diagnosis and treatment of disease.

2

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

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

10

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

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

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

16 (c) not charge the patient any additional amount or copayment except as specified under [sections
17 11 and 65] and by rule.

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

21

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

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

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

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

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

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

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

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

21 (b) A health care facility that fails to provide full access to all individuals pursuant to subsection
22 (6)(a) must be investigated by the department and may be barred from receiving health security system
23 funds in subsequent years, at the discretion of the department, subject to the review procedures in [section
24 44].

25

26 **NEW SECTION. Section 41. Payment mechanisms.** (1) Physicians, advanced practice nurses, and
27 other independent professional providers may choose from a variety of payment mechanisms for
28 reimbursement. These payment methods may include but need not be restricted to fee-for-service,
29 capitation, or a salary from a globally budgeted health care facility for a defined level of service. [Sections
30 1 through 82, 101, 104, and 105] may not be construed to permit discrimination in eligibility for

1 reimbursement against a class of professional providers who are providing services within the scope of
2 practice permitted by law.

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

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

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

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

25

26 **NEW SECTION. Section 42. Representation of providers in negotiations.** (1) The department
27 shall recognize professional associations to represent professional providers in each system region in
28 negotiations with the department on reimbursement and other professional issues.

29 (2) The department shall establish procedures allowing each category of professional provider in
30 a system region to choose, by majority vote of that category of professional provider, the organization or

1 association in each region that may be their representative in all negotiations with the department.

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

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

8
9 **NEW SECTION. Section 43. Limits on aggregate payments.** (1) Notwithstanding [section 42],
10 the department shall establish a limit on the aggregate annual payments to an individual professional
11 provider or discounts on reimbursements above a specified amount of aggregate billing, as negotiated with
12 the professional associations.

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

16
17 **NEW SECTION. Section 44. Integrated delivery systems allowed.** (1) (a) A health care facility
18 and a group of physicians and other professional providers may organize as an integrated delivery system
19 providing the full spectrum of health care services to a defined population of enrollees. An integrated
20 system may be paid by the health security system on a capitated basis to provide the full spectrum of
21 benefits covered by the health security system. [Sections 1 through 82, 101, 104, and 105] may not
22 prevent an integrated delivery system from offering benefits beyond those set forth in [sections 9 through
23 14]. The fee level for capitated reimbursement must be negotiated on a regional basis by professional
24 provider associations and the department, based on health risk of enrollees and any other relevant factors,
25 and must apply uniformly to all professional providers in the region.

26 (b) Health care facilities participating under this capitated arrangement as part of an integrated
27 delivery system are exempt from negotiating separate operating budgets with the health security system.
28 However, they are not exempt from regulation of capital investment as specified in [sections 47 and 48].

29 (2) (a) The profits of health care facilities and professional providers organizing as integrated
30 delivery systems that are for-profit are restricted to a fair rate of return to be negotiated with the

1 department and are subject to the same restrictions on capital expansion that apply to all other health
2 facilities, clinics, and professional providers.

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

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

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

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

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

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

19

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

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

30 (3) During the open enrollment period, an individual may enroll in another capitated practice or

1 choose a primary care provider in the fee-for-service sector.

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

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

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

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

15

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

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

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

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

1 services.

2

3 **NEW SECTION. Section 47. Capital expenditures.** (1) (a) The purpose of this section is to ensure
4 that health care facilities that are reimbursed by the health security system do not engage in unnecessary
5 capital expenditures and thereby contribute to health care cost inflation. The provisions of Title 50, chapter
6 5, part 3, do not apply to a facility under this section.

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

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

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

18 (i) exceeds \$500,000;

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

20 (iii) adds a new service or license category.

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

25 (f) When a health care facility or individual acting on behalf of a health care facility obtains by lease
26 or comparable arrangement any facility or part of a facility or any equipment for a facility the market value
27 of which would have been a capital expenditure, the lease or arrangement must be considered a capital
28 expenditure for purposes of this section.

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

- 1 (a) fill unmet needs;
- 2 (b) eliminate duplicative, inappropriate, or unnecessary services by regionalizing services in
3 appropriate facilities;
- 4 (c) encourage the expansion of those facilities that have superior records of consumer satisfaction
5 and operating efficiency;
- 6 (d) convert to nonacute care uses general acute care hospitals of less than 150 licensed beds
7 within standard metropolitan statistical areas;
- 8 (e) ensure that health care facilities are accessible to all parts of the community, including the
9 disabled and populations with special medical needs;
- 10 (f) promote joint, cooperative, or shared health care resources;
- 11 (g) ensure the development of new technologies in appropriate facilities; and
- 12 (h) meet the special needs of rural hospitals.
- 13 (3) (a) The department shall establish procedures for the review of capital expenditures.
- 14 (b) The procedures may provide that all capital expenditures in a particular region or for one or
15 more particular purposes submitted over a period of time of up to 1 year may be reviewed together at the
16 same hearing.
- 17 (4) Notwithstanding the provisions of subsection (2), the department may approve capital
18 expenditures for either of the following reasons:
- 19 (a) if necessary to meet parking, seismic safety, fire safety, physical accessibility for the disabled,
20 energy or water conservation, or other public health and safety requirements of federal, state, or local
21 government; or
- 22 (b) if necessary to replace a physical plant and equipment damaged or destroyed by fire,
23 earthquake, or other natural disaster.
- 24 (5) Notwithstanding any other provision of law, the department may approve the temporary or
25 permanent conversion of general acute care beds to skilled nursing beds or the addition of skilled nursing
26 beds to any general acute care hospital.
- 27
- 28 **NEW SECTION. Section 48. Capital allocation.** (1) Once a capital expenditure request has been
29 approved by the department, it may be funded.
- 30 (2) No later than January 1 of [the second year following the effective date of this act], the

1 department shall report on the capital needs of health facilities and clinics in each system region. In
2 addition to any other matter considered relevant by the department, the report must identify the capital
3 needs of all of the following:

- 4 (a) county health care facilities;
- 5 (b) underserved geographic areas with per capita investment in health care facilities substantially
6 different from the state average; and
- 7 (c) geographic areas where the distance to health care facilities imposes a barrier to care.

8
9 **NEW SECTION. Section 49. Cost control measures.** The department may not carry out any cost
10 control measure that limits access to care that is needed on an emergency or urgent basis or that is
11 medically appropriate for treatment of a patient’s medical condition.

12
13 **NEW SECTION. Section 50. Cost control.** (1) In order to control costs, the department shall strive
14 at all times to do all of the following:

- 15 (a) eliminate administrative and other costs that do not contribute to health care;
- 16 (b) identify and eliminate wasteful and unnecessary care that does not benefit patients receiving
17 that care; and
- 18 (c) identify and foster those measures that prevent disease and maintain health.

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

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

28
29 **NEW SECTION. Section 51. Request to legislature for increased appropriation.** (1) In the event
30 that cost control is required by [section 31(2)], the department may request that the legislature increase

1 appropriations for the health security system. Any request must be accompanied by a report on the causes
2 of the increase in expenditures beyond the increase in gross domestic product, adjusted for population, and
3 measures taken to control costs pursuant to [section 50].

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

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

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

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

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

17

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

22

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

27 (a) The department shall guarantee that specialized, experimental, high-technology, and
28 high-expense procedures and services are performed at the highest level of competency possible and are
29 fully available to all Montanans with conditions whose effective treatment requires that care.

30 (b) The department shall guarantee that the specialized services available in tertiary care referral

1 centers are not in oversupply or otherwise available in ways that are likely to foster their inappropriate use.

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

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

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

8

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

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

20

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

24

25 **NEW SECTION. Section 56. Enforcement.** (1) A provider that receives funds or provides care
26 pursuant to [sections 1 through 82, 101, 104, and 105] may not discriminate against a person seeking care
27 on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, medical
28 condition, marital status, sex, sexual orientation, age, wealth, or any other basis prohibited by the civil
29 rights laws of this state. [Sections 1 through 82, 101, 104, and 105] may not require a professional
30 provider or health care facility or clinic to perform a particular service when either of the following applies:

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

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

5 (2) A person who is eligible for health care services under [sections 1 through 82, 101, 104, and
6 105] has the right to equitable access of medically appropriate health care and has standing to enforce this
7 section.

8
9 **NEW SECTION. Section 57. Rules for financial interest in health care facilities -- disclosure by**
10 **providers.** (1) Standards and criteria must be established by rule to ensure that health care providers may
11 not have a financial interest in laboratory and diagnostic facilities to which they refer patients for tests,
12 procedures, or services.

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

16
17 **NEW SECTION. Section 58. Mandatory exclusion of providers.** The department shall exclude the
18 following providers from participation in any program under [sections 1 through 82, 101, 104, and 105]:

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

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

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

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

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

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

29 (2) a provider whose license to provide health care has been revoked or suspended by any state
30 licensing agency or who otherwise lost a license or the right to apply for or renew a license for reasons

1 bearing on the individual's or entity's professional competence, professional performance, or financial
2 integrity;

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

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

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

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

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

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

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

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

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

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

25

26 **NEW SECTION. Section 59. Discretionary exclusion of providers.** The department may exclude
27 the following providers from participation in any program under [sections 1 through 82, 101, 104, and
28 105]:

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

30 (2) a person, including an organization, agency, or other entity but excluding a covered individual,

1 that presents or causes to be presented to an officer, employee, or agent of the department a claim or
2 request for payment that the department determines meets any of the following descriptions:

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

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

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

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

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

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

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

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

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

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

28 (i) a discount or other reduction in price obtained by a provider of service or other entity if the
29 reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by
30 the provider or entity under the health security system;

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

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

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

10
11 **NEW SECTION. Section 60. Civil penalties.** In addition to any other penalties prescribed by law,
12 the department may impose a civil money penalty of not more than \$5,000 for each violation of [sections
13 56 through 63]. In addition, a person who violates [sections 56 through 63] is subject to an assessment
14 of not more than twice the amount of unlawful payment or damages sustained by the state resulting from
15 the violation. In addition, the department may make a determination in the same proceeding to exclude the
16 person from participation in the health security system.

17
18 **NEW SECTION. Section 61. Rules for review of exclusion.** (1) The department shall establish
19 regulations and procedures for the review of any action that may result in exclusion or penalties under
20 [sections 56 through 63].

21 (2) In the case of exclusion or limitation under [section 59(4)], the review procedures must be
22 consistent with those required by Title 37. The department and all other individuals participating in the
23 review procedures have all the immunities provided to a hospital by 37-2-201 and 37-3-401 through
24 37-3-404.

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

27
28 **NEW SECTION. Section 62. Exclusion -- termination.** (1) An exclusion must be effective at the time
29 and upon the conditions as the department determines.

30 (2) An exclusion may be terminated at the time and upon the conditions as the department

1 determines.

2

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

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

8

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

11 (2) Any money appropriated under subsection (1) must be repaid with interest to the general fund
12 from the health security fund within 2 years unless a longer period is authorized by the legislature.

13

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

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

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

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

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

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

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

29 (4) After the first year of benefits under [sections 1 through 82, 101, 104, and 105], a copayment
30 may not be required for any covered benefit, other than as established by the department pursuant to

1 [section 11]. However, the department may extend the period of copayment under subsection (2) of this
2 section for up to 1 additional year upon making a finding that the health security system is not yet capable
3 of absorbing the full cost of the benefits.

4
5 **NEW SECTION. Section 66. Health care worker staffing ratio changes.** (1) Beginning [the
6 effective date of this act], a health care facility or professional provider may not increase the ratio of
7 patients to licensed or registered nurses without the approval of the department. Petitions for waivers must
8 be made public and may not be approved without 60 days' public notice.

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

12
13 **NEW SECTION. Section 67. Transition of capitated integrated health systems.** (1) An individual
14 enrolled in a capitated integrated health delivery system on December 31 of [the first year following the
15 effective date of this act] must be considered enrolled in that integrated health delivery system for the
16 purposes of initial benefits effective January 1 of [the second year following the effective date of this act],
17 unless the particular integrated delivery system in which the individual is enrolled has not been registered
18 by the health security system or has selected a noncapitated mode of reimbursement under the health
19 security system.

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

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

28
29 **NEW SECTION. Section 68. Hearings and judicial review.** (1) Any person aggrieved by a decision,
30 order, rate, rule, regulation, action, or failure to act by the department or a regional health care planning

1 board may seek judicial review.

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

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

8 (2) In any action or proceeding challenging a legislative amendment to [sections 1 through 82, 101,
9 104, and 105], the following apply:

10 (a) The party or parties asserting the validity of the amendment have the burden of proving by clear
11 and convincing evidence that the amendment is consistent with the purposes of [sections 1 through 82,
12 101, 104, and 105]. The purposes of [sections 1 through 82, 101, 104, and 105] include not only the
13 intent, findings, and declarations set forth in [sections 2 and 3] but also include the actions employed to
14 achieve the stated aims.

15 (b) A legislative amendment that is inconsistent with the purposes of [sections 1 through 82, 101,
16 104, and 105] must be declared invalid, and the prevailing plaintiff, other than the department, an officer,
17 or a member of a department, board, or agency established by [sections 1 through 82, 101, 104, and 105]
18 must be awarded cost of suit and reasonable attorney fees.

19

20 **NEW SECTION. Section 69. Hearings.** (1) Any quasi-adjudicatory hearing required by law must
21 be conducted in accordance with Title 2, chapter 4, except as provided in [sections 1 through 82, 101,
22 104, and 105].

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

26

27 **NEW SECTION. Section 70. Insurance and practice outside the health security system.** (1) Any
28 person providing or offering health care or insurance to any individual for a fee or other consideration that
29 covers benefits available under the health security system shall inform these individuals, including
30 prospective customers, in writing of the benefits for which they may be eligible under the health security

1 system.

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

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

10

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

13

14 **NEW SECTION. Section 72. Payment and provision of services.** (1) Except as provided in [section
15 21], a participating health care facility or professional provider may not charge any person, including
16 individuals not eligible for benefits under the health security system, for services or procedures that are
17 covered benefits under the health security system, other than for a copayment as permitted.

18 (2) Except as provided in [section 39], a participating health care facility or professional provider
19 may provide to any person services or procedures that are not covered benefits under [sections 1 through
20 82, 101, 104, and 105], subject to the following conditions:

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

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

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

30

1 **NEW SECTION. Section 73. Coordination with other laws -- exemption from state and federal**
2 **antitrust laws.** (1) An action taken by or on behalf of the department or by any person as authorized by
3 [sections 1 through 82, 101, 104, and 105] may not be considered a violation of unfair trade practices.
4 (2) It is the intent of the legislature to ensure that all Montanans receive high-quality health care
5 coverage in the most efficient and cost-effective manner possible.
6 (a) In furtherance of this intent, the legislature finds and declares that it is in the public interest to
7 enhance the ability of professional providers and health care facilities to form bargaining units for the
8 purpose of contracting for the delivery of health care services and that it is in the public interest for the
9 health security system to contract with vendors, professional providers, and health care facilities to further
10 the purposes of [sections 1 through 82, 101, 104, and 105].
11 (b) The legislature further finds and declares that the existing marketplace for health care services,
12 relying on contracts between individual providers, both institutional and professional, and individual insurers
13 and purchasers has not proven effective and has been unable to provide quality and efficient health care
14 to all Montanans.
15 (c) The legislature further finds and declares that the efficient operation of the health security
16 system, including its salient purpose of providing universal, comprehensive, accessible, portable, and
17 publicly administered health care and providing the greatest freedom of choice to the health care consumer,
18 requires the displacement of competition among providers, insurers, and purchasers of health care services.
19 (d) It is the intent of the legislature, that the formation of groups and combinations of providers
20 and health care facilities and the concentration of purchasing power and regulatory department in the health
21 security system should be exempt from federal antitrust restraints.
22 (3) The legislature finds and declares all of the following:
23 (a) There is a compelling state public interest in each action undertaken by or on behalf of the
24 department and every other state and local agency, board, council, and officer acting under and in
25 furtherance of [sections 1 through 82, 101, 104, and 105], including but not limited to those actions
26 otherwise considered in restraint of trade.
27 (b) [Sections 1 through 82, 101, 104, and 105] prescribe and exercise the degree of state direction
28 and supervision over health care services that provide for state action immunity under federal antitrust laws
29 for activities undertaken by local governmental entities in carrying out their prescribed functions under the
30 health security system.

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

6
7 NEW SECTION. Section 74. Compliance with federal health care reform legislation. (1) The
8 department shall determine those provisions of [sections 1 through 82, 101, 104, and 105] and those
9 actions taken pursuant to [sections 1 through 82, 101, 104, and 105] that must be modified to achieve
10 compliance with requirements for state health plans as specified by federal laws or regulations, including
11 those enacted after [the effective date of this act].

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

17 (b) The department shall construe or modify any regulation promulgated under [sections 1 through
18 82, 101, 104, and 105] as necessary to achieve compliance with federal health care reform legislation.

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

22
23 NEW SECTION. Section 75. Federal waivers. (1) The department shall seek all appropriate federal
24 waivers, exemptions, agreements, or legislation that will allow all federal payments for medical, mental
25 health, and long-term care made in this state to be paid directly to the department for the purposes of the
26 health security system and that will allow for the assumption by the health security system of the
27 responsibility for all benefits previously paid by the federal government.

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

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

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

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

9
10 **NEW SECTION. Section 76. Health security fund account.** (1) There is a health security fund
11 account in the state treasury for the administration and enforcement of [sections 1 through 82, 101, 104,
12 and 105].

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

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

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

24
25 **NEW SECTION. Section 77. Appropriations.** (1) It is the intent of the legislature that all money
26 in the health security fund be appropriated to the health security system to support implementation of
27 [sections 1 through 82, 101, 104, and 105].

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

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

1 the balance remaining in the health security fund at the end of the fiscal year is greater than 1% of the
2 system budget and the reserve account is fully funded, the department shall request that the legislature
3 reduce the tax rates in [sections 82 through 100].
4

5 **NEW SECTION. Section 78. Federal contributions to health security fund.** The department shall
6 seek all necessary waivers, exemptions, agreements, or legislation to allow all current federal payments for
7 health care to be paid directly to the health security system, which shall then assume responsibility for all
8 benefits and services previously paid for by the federal government with those funds. In obtaining the
9 waivers, exemptions, agreements, or legislation, the department shall seek from the federal government
10 a contribution for health care services in Montana that may not decrease in relation to the contribution to
11 other states as a result of the waivers, exemptions, agreements, or legislation.
12

13 **NEW SECTION. Section 79. State contributions to health security fund.** (1) The department shall
14 seek all necessary waivers, exemptions, agreements, or legislation to allow all current state payments for
15 health care to be paid directly to the health security system, which shall then assume responsibility for all
16 benefits and services previously paid for by state government with those funds. In obtaining the waivers,
17 exemptions, agreements, or legislation, the department shall seek from the legislature a contribution for
18 health care services that may not decrease in relation to state government expenditures for health care
19 services in 1997, corrected for changes in the state gross domestic product and population.

20 (2) The department may transfer funding for state programs for health services to the health
21 security system.
22

23 **NEW SECTION. Section 80. County and local contributions to health security fund.** The
24 department shall seek all necessary waivers, exemptions, agreements, or legislation to allow all current
25 county or other local agency payments for health care, including employee health benefits and health
26 benefits for retired employees, to be paid directly to the health security system, which shall then assume
27 responsibility for all benefits and services previously paid for by counties or other local agencies or local
28 governments with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the
29 department shall seek contributions for health care services that may not decrease in relation to
30 expenditures for health care services in 1997, corrected for changes in the state gross domestic product

1 and population.

2

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

8

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

14

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

18 (2) The tax rate is 10% of taxable income, as defined in 15-30-101, but not less than \$50 per
19 household per year.

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

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

26

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

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

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

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

5
6 **NEW SECTION. Section 85. Employer option.** (1) [Sections 1 through 82, 101, 104, and 105]
7 may not be construed to interfere with an employer choosing to pay, in part or in full, the individual health
8 security income tax for an employee.

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

11
12 **NEW SECTION. Section 86. Employer health security system fund payroll tax.** (1) (a) There is
13 imposed on each employer a health security fund payroll tax in an amount equal to 7.3% of the employer's
14 payroll in the preceding calendar quarter, except that if an employer is subject to 15-30-204(2), the tax is
15 an amount equal to 7.3% of the employer's payroll in the preceding week.

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

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

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

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

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

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

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

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

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

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

19 (c) Tax payments required by subsection (1) must be made with the return filed pursuant to
20 15-30-204. The department shall first credit a payment to the liability under 15-30-202 and credit any
21 remainder to the health security fund account provided in [section 76].

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

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

30 (5) Returns and remittances under subsection (3) and any information obtained by the department

1 during an audit are subject to the provisions of 15-30-303, but the department may disclose the information
2 to the department under circumstances and conditions that ensure the continued confidentiality of the
3 information.

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

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

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

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

16

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

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

23 (3) An employer is exempt from any other provisions of [sections 1 through 82, 101, 104, and
24 105] to the extent compliance with the provision would be preempted by federal law. It is the intent of
25 the legislature that the provisions of [sections 1 through 82, 101, 104, and 105] be construed to be
26 consistent with federal law.

27

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

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

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

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

10

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

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

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

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

24 (b) In the case of an employer that is exempt from the payroll tax obligation pursuant to [section
25 87], the amount of credit to be applied to the employee's tax obligation must be determined in the same
26 manner as in the case of a nonexempt employer.

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

28

29 **NEW SECTION. Section 90. Corporate income health security fund surtax.** After the amount of
30 tax liability has been computed under 15-31-121(1) through (3), each corporation subject to taxation under

1 Title 15, chapter 31, part 1, shall add a health security fund surtax of 6 3/4%. Revenue from this section
2 must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund account
3 established in [section 76].

4
5 **NEW SECTION. Section 91. Health security fund cigarette tax.** There is imposed a health security
6 fund tax, in addition to the tax imposed in 16-11-111, of 18 cents on each package containing 20
7 cigarettes, and when packages contain more or less than 20 cigarettes, a tax on each cigarette equal to
8 1/20th the tax on a package containing 20 cigarettes is imposed. Revenue from this section must, in
9 accordance with 15-1-501(6), be deposited to the credit of the health security fund account established
10 in [section 76]. The tax in this section is subject to 16-11-111(2) through (6).

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

18
19 **NEW SECTION. Section 93. Health security fund tax on beer.** In addition to the taxes levied in
20 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
21 beer sold in Montana by any wholesaler. The tax is due at the end of each month from a wholesaler on
22 beer sold during that month. For any beer that is sold in containers other than in barrels or in barrels of
23 more or less capacity than 31 gallons, the quantity content must be computed by the department in
24 determining the amount due. Revenues from this section must, in accordance with 15-1-501(6), be
25 deposited to the credit of the health security fund account established in [section 76].

26
27 **NEW SECTION. Section 94. Liquor health security fund tax.** In addition to the excise tax provided
28 for in 16-1-401 and the license tax provided for in 16-1-404, the department shall collect at the time of sale
29 and delivery of any liquor under any provisions of the laws of the state a health security fund tax of 16%
30 of the retail selling price on all liquor sold and delivered in the state. Revenue from this section must, in

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

3

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

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

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

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

14

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

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

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

23

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

1 petroleum, other mineral or crude oil, or natural gas produced by the person.

2
3 **NEW SECTION. Section 98. Metalliferous mines health security fund tax.** In addition to the tax
4 provided for in 15-37-103, the annual health security fund tax to be paid by a person engaged in or carrying
5 on the business of working or operating any mine or mining property in the state from which gold, silver,
6 copper, lead, or any other metal or metals or precious or semiprecious gems or stones are produced is
7 1.85% computed on the gross value of product that may have been derived by the person from the mining
8 business, work, or operation within this state during the calendar year immediately preceding.

9
10 **NEW SECTION. Section 99. Health security fund gambling machine licensing tax.** There is
11 imposed upon each licensed operator who is issued a permit under this part a health security fund tax of
12 15% of the gross income from each video gambling machine licensed under this part. Revenue from this
13 section must, in accordance with 15-1-501(6), be deposited to the credit of the health security fund
14 account established in [section 76].

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

20
21 **NEW SECTION. Section 101. Legislative amendment.** (1) The provisions of [sections 1 through
22 82, 101, 104, and 105] may not be amended except to further its purposes by a statute passed by a vote
23 of two-thirds of each house or upon approval by the electorate.

24 (2) The two-thirds vote requirement of subsection (1) does not apply to any provision of [sections
25 1 through 82, 101, 104, and 105] that meets any of the following requirements:

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

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

30 (c) the provision must be amended to achieve compliance with federal health care reform legislation,

1 pursuant to [sections 74 and 75], in which case a majority of the membership in each house is sufficient
2 for amendment.

3

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

5 **"15-1-501. Disposition of money from certain designated license and other taxes.** (1) The state
6 treasurer shall deposit to the credit of the state general fund in accordance with the provisions of
7 subsection (6) all money received from the collection of:

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

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

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

12 (d) telephone company license taxes under chapter 53; and

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

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

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

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

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

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

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

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

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

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

1 (5) Oil and natural gas production taxes allocated under 15-36-324(7)(a) must be deposited in the
2 general fund.

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

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

11

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

13 **"17-5-408. Percentage of income, corporation license, and cigarette tax pledged.** (1) (a) The state
14 pledges and appropriates and directs to be credited as received to the debt service account, except as
15 provided in [section 83], money received from the collection of the individual income tax and, except as
16 provided in 15-31-702 and [section 90], money received from the collection of the corporation license and
17 income tax, as provided in 15-1-501, as may at any time be needed to comply with the principal and
18 interest and reserve requirements stated in 17-5-405(4).

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

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

1 referred to in this subsection."
2

3 **NEW SECTION. Section 104. Insurance provisions not applicable.** The provisions of Title 33 do
4 not apply to [sections 1 through 82, 101, and 105 and this section].
5

6 **NEW SECTION. Section 105. Construction.** [This act] must be construed as necessary to comply
7 with federal health care legislation, consistent with the intent of the act to establish a single payor for
8 health care with freedom of choice of professional providers and a single standard of care for all Montanans
9 eligible for particular services under the health security system.
10

11 **NEW SECTION. Section 106. Codification instruction.** (1) [Sections 1 through 82, 101, 104, and
12 105] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50,
13 chapter 4, apply to [sections 1 through 82, 101, 104, and 105].

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

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

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

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

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

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

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

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

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

1 the provisions of Title 23, chapter 5, part 6, apply to [section 99].

2 (11) [Section 100] is intended to be codified as an integral part of Title 15, chapter 65, part 1, and
3 the provisions of Title 15, chapter 65, part 1, apply to [section 100].

4

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

9

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0503, 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 Department of Public Health and Human Services to define the benefits; outlining the department's duties and powers; providing for transfer of state programs upon study by the department; providing for public hearings, monitoring and evaluation; providing for: exempt employers and employees; collection from collateral sources; budgets and expenditure limits for the health security system; choices in forms of provider reimbursement and payment mechanisms; provider representation in negotiations; integrated delivery systems; capital expenditures; cost control measures; enforcement mechanisms; a phase-in of the health security system; hearings and judicial review; practice outside of the health security system; open participation; coordination with other laws; compliance with federal legislation; the department to apply for necessary federal waivers; creating health security fund taxes on personal income, employer payroll, corporate income, cigarettes, tobacco products, beer, liquor, table wines, coal production, oil and gas production, metalliferous mine production, gambling machine licensing, and accommodations; creating a health security fund personal income tax credit; creating a health security system payroll tax phase-in, option, and credit; and providing for two-thirds vote for certain future legislative amendments.

ASSUMPTIONS:

1. This act will provide health care coverage for all Montana residents.
2. Work commissioned by the Montana Health Care Authority (MHCA) estimated the cost of a single-payer system statewide to be \$2.588 billion during fiscal 1996 and \$2.737 billion during fiscal 1997. (Reference: MHCA Statewide Universal Health Care Access Plans, using estimated growth rate of 5.75% annually.) Using these amounts and continuing growth rates of 5.75% annually, cost of a single-payor plan during fiscal 1998 would be \$2.894 billion and during fiscal 1999 would be \$3.060 billion. 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 seven and eight below.)
3. All funds for state programs which pay for health care services, such as Medicaid, the Mental Health Access Plan (MHAP), state employee coverage, and health care coverage provided through the Department of Corrections will be transferred to the single-payer plan. The populations previously served then will be covered by the single-payer plan.
4. 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 eligibles. Medicaid covers items not usually covered in most health insurance plans.) If the federal waiver were not approved, Montana would likely have to provide a supplemental package of benefits to Medicaid eligibles, e.g., "wrap-around" services such as transportation 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 fiscal 1996 level, to offset a portion of the costs of the Medicaid eligible population.
5. 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, MHAP, and state employee health plans, will administer the single-payer plan under the direction of the Department of Public Health and Human Services (DPHHS). No new

(Continued)

Dave Lewis 2-18-97
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

BILL CAREY, PRIMARY SPONSOR DATE

Fiscal Note for HB0503, as introduced

HB 503

(continued)

- staff have been added for purposes of this fiscal note. If the DPHHS determines a need for additional staff or funding to carry out this legislation, a provision would have to be made to secure these resources.
6. 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.
 7. The state will receive an ERISA waiver from the federal government.
 8. 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.
 9. The sole proprietor payroll health security system fund tax would be effective January 1, 1999. The individual income health security system fund tax would be effective January 1, 2000. All other health security system fund taxes under this proposal would become effective January 1, 1998.
 10. During the 1995 Legislative session, an estimate of the revenue generated under this proposal was prepared. At that time, an estimated \$1.304 billion would have been generated during the 1997 biennium under the various proposed taxes. The total impact for subsequent biennia, once all taxes were fully phased-in, was anticipated to be \$1.809 billion. For purposes of this fiscal note, again, revenues of approximately \$1.3 billion are projected to be generated during the 1999 biennium, and fully phased-in during subsequent biennia would generate \$1.8 billion.
 11. 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 seven and eight 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:

	<u>FY98</u>	<u>FY99</u>
<u>Expenditures:</u>	<u>Difference</u>	<u>Difference</u>
Employer Payroll Tax	\$39,815,366	\$38,677,981
State Employee/Retiree		
Health Insurance	<u>(41,344,467)</u>	<u>(41,684,359)</u>
Total	(1,529,101)	(3,006,378)
<u>Funding:</u>		
General Fund	(1,386,539)	(2,285,943)
Other Funds	<u>(142,562)</u>	<u>(720,435)</u>
Total	(1,529,101)	(3,006,378)
<u>Revenues:</u>		
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	<u>4,265,000</u>	<u>8,830,000</u>
Total	399,603,000	904,454,000

Net Impact on General Fund Balance: (Revenues minus Expenditures)

General Fund (01)	1,386,539	2,285,943
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(Continued)

TECHNICAL NOTES:

1. 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.
2. Section 10 (1) and (3) appear to be in conflict. Part (3) indicates the DPHHS shall consider long-term care benefits and make recommendations to the legislature, while part (1) requires the department to adopt rules to implement a medical benefits package.
3. The bill should be amended to clarify that the taxes will not be enacted until all of the necessary waivers are approved.