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SENATE BILL NO. 511

INTRODUCED BY J. ELLINGSON

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 PHASE IN OF THE HEALTH SECURITY SYSTEM; PROVIDING FOR HEARINGS AND JUDICIAL REVIEW; PROVIDING FOR PRACTICE OUTSIDE OF THE HEALTH SECURITY SYSTEM; PROVIDING FOR OPEN PARTICIPATION; PROVIDING FOR COORDINATION WITH OTHER LAWS; PROVIDING FOR COMPLIANCE WITH FEDERAL LEGISLATION; PROVIDING FOR THE 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; PROVIDING FOR A TWO-THIRDS VOTE FOR CERTAIN FUTURE LEGISLATIVE AMENDMENTS; PROVIDING FOR CONTINGENT SUSPENSION AND VOIDNESS; AND AMENDING SECTION 15-1-501, MCA."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 82, 101, 103, and 104] may be known as



1 the "Montana Health Security Act".

2

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

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

6 (2) A significant proportion of Montana's people lack any form of health care coverage.

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

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

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

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

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

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

17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16

17 **NEW SECTION. Section 4. Definitions.** As used in [sections 1 through 82, 101, 103, and 104], unless
18 the context requires otherwise, the following definitions apply:

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

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

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

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

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

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

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

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

6 (8) "Health security system" means the program of comprehensive health services administered by the
7 department as set out in [sections 1 through 82, 101, 103, and 104] and all policies and directives of the
8 department.

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

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

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

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

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

20 (a) a fee for each service provided;

21 (b) capitation;

22 (c) salary.

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

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

27 (16) "Professional provider" means an individual licensed to provide health care services pursuant to Title
28 37, chapters 3 through 8, 10 through 17, and 20 through 29.

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

30 (18) "Resident" means a person who fulfills residence requirements as described in 1-1-215 or as

1 otherwise defined by statute.

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

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

8 (21) "System" means the health security system established by [sections 1 through 82, 101, 103, and
9 104].

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

12 (23) "Tertiary care" means specialized diagnostic and treatment services designated by the department.
13

14 **NEW SECTION. Section 5. Eligibility.** All Montanans who meet residency requirements, as described
15 in 1-1-215 and otherwise defined by the statute, are eligible for covered benefits specified in [sections 9 through
16 14].
17

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

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

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

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

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

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

3

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

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

11

12 **NEW SECTION. Section 8. County obligations.** [Sections 1 through 82, 101, 103, and 104] do not
13 relieve the counties of their obligation under Title 53, chapter 2.

14

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

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

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

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

23

24 **NEW SECTION. Section 10. Medical benefits.** (1) The department shall, by the later of January 1,
25 2000, or within 6 months of [the effective date of this act] adopt rules to implement a medical benefit package.

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

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

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

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

4

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

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

12

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

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

17

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

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

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

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

28

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

1 to all individuals.

2

3 **NEW SECTION. Section 15. Department health security system powers and duties.** (1) The
4 department's powers include all powers necessary and proper to implement [sections 1 through 82, 101, 103,
5 and 104] and to promote its underlying aims and purposes. These broad powers include but are not limited to
6 the power to set rates and adopt rules on all matters relating to the implementation of [sections 1 through 82, 101,
7 103, and 104].

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

10 (a) implement statutory eligibility standards;

11 (b) adopt annually a benefits package for consumers;

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

14 (d) develop and implement separate formulas for determining budgets pursuant to [sections 32 through
15 38];

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

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

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

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

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

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

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

- 1 (l) administer the revenue of the health security system in accordance with [sections 78 through 82];
- 2 (m) procure funds (including loans), lease or purchase property, and obtain appropriate liability and other
- 3 forms of insurance for the health security system and its employees and agents;
- 4 (n) establish, appoint, and fund, as part of the administration of the health security system, the regional
- 5 health care planning boards;
- 6 (o) administer all aspects of the health security system that include but are not limited to the following:
- 7 (i) establish standards and criteria by rule for allocation of operating funds;
- 8 (ii) meet regularly with the regional health care planning boards to review the impact of the health security
- 9 system and its policies on the regions;
- 10 (iii) budget to most equitably meet the health care needs of the population of the state as a whole and
- 11 the population within each region pursuant to the specific purposes that have been established;
- 12 (iv) achieve the best pharmaceutical drug prices for the health security system; and
- 13 (p) gather and analyze data necessary for the efficient and equitable functioning of the health security
- 14 system pursuant to 50-4-502.
- 15 (3) In addition to all other powers conferred under [sections 1 through 82, 101, 103, and 104], the
- 16 department may:
- 17 (a) employ appropriate staff as necessary to implement [sections 1 through 82, 101, 103, and 104];
- 18 (b) delegate to appointed staff any aspect of the health security system that is the responsibility of the
- 19 department. Individuals employed by the department or by any department or state agency that is made a part
- 20 of the health security system shall perform their duties as the department assigns them.
- 21 (c) employ and direct attorneys on staff or as outside counsel in the defense or implementation of any
- 22 provision of [sections 1 through 82, 101, 103, and 104];
- 23 (d) sue and be sued to enforce any provision of [sections 1 through 82, 101, 103, and 104];
- 24 (e) seek, at the department's discretion, legal advice or counsel from the attorney general;
- 25 (f) incur travel expenses that are necessary for the performance of the department's duties;
- 26 (g) issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent
- 27 to the administration of the health security system;
- 28 (h) adopt rules for procedures and standards for competitive bidding that govern the contracts authorized
- 29 by this section. The provisions of Title 18 do not apply to the competitive bidding requirements.
- 30 (i) ensure that all existing statutes regarding confidentiality of medical records apply to the health security

1 system. A policy, directive, or study by the department may not be adopted that compromises confidentiality of
2 medical records as established by law.

3

4 **NEW SECTION. Section 16. Transfer of state facilities -- programs.** (1) [Sections 1 through 82, 101,
5 103, and 104] do not prevent the legislature from transferring to the health security system programs for health
6 care, including mental health care for patients in state hospitals and other health care facilities owned by the state
7 and facilities located in state prisons.

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

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

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

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

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

26 (a) statewide planning and other programs of the department;

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

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

29 and

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

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

5

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

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

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

11

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

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

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

19

20 **NEW SECTION. Section 19. Monitoring and evaluation.** (1) The department shall establish a
21 standard set of indicators and methods to be used to assess the effectiveness of the health security system in
22 implementing and fulfilling the intent and purposes of [sections 1 through 82, 101, 103, and 104]. The indicators
23 and methods should include but are not limited to the current federal center for disease control and prevention's
24 consensus list of population health outcome indicators and indicators of child health, maternal health, safety and
25 cost of births, promptness and appropriateness of treatment for cancer and other diseases, surgical survival and
26 success rates for common procedures, functional status in the elderly, communicable disease rates, monitoring
27 of out-of-pocket expenditures, availability of services including geographic proximity and waiting times, the
28 number and types of staff employed by professional providers, and the number of each category of professional
29 provider giving hands-on care.

30 (2) As a condition of reimbursement, professional providers and health care facilities must be required

1 to report to the department a certain amount of clinical data to be used to assist in the health security system's
2 health outcome monitoring effort and for the purposes of improving the effectiveness of practice by professional
3 providers and health care facilities.

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

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

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

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

16

17 **NEW SECTION. Section 20. Collective bargaining protected.** [Sections 1 through 82, 101, 103, and
18 104] may not be construed to affect or diminish the benefits that an individual may have under a collective
19 bargaining agreement.

20

21 **NEW SECTION. Section 21. Employees covered by health plan subject to preemption.** (1) To the
22 extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that,
23 under federal law, preempts provisions of [sections 1 through 82, 101, 103, and 104] shall first seek benefits
24 under that contract or plan before receiving benefits under the health security system.

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

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

29 (4) [Sections 1 through 82, 101, 103, and 104] are not intended nor may they be construed to discourage
30 recourse to contracts or plans that are protected by federal law.

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

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

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

9

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

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

18 (i) an insurer, as defined in 33-1-201, including the medical components of automobile, homeowner's,
19 and other forms of insurance;

20 (ii) health care and pension plans;

21 (iii) employers;

22 (iv) employee benefits contracts;

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

24 (vi) a judgment for damages for personal injury; and

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

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

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

28 (ii) a governmental unit, agency, or service to the extent that subrogation is prohibited by law. An entity
29 described in subsection (2)(a) is not excluded from the obligations imposed by [sections 21, 75, and 87] by virtue
30 of a contract or relationship with a governmental unit, agency, or service.

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

4

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

10

11 NEW SECTION. **Section 24. Assignment from collateral sources.** Use of an eligibility card for or
12 receipt of health care services under the health security system for which an individual is entitled to coverage,
13 reimbursement, indemnity, or other compensation from a collateral source is considered an assignment by the
14 individual to the health security system of the person's rights from or against the collateral source to the extent
15 of services provided under [sections 1 through 82, 101, 103, and 104]. Any provision or agreement between the
16 individual and the collateral source prohibiting assignment of rights is not applicable to an assignment under this
17 section. Except as specified in [sections 21, 75, and 87], [sections 1 through 82, 101, 103, and 104] may not
18 affect a person's right to benefits or money or the person's right of action from or against a collateral source.

19

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

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

28

29 NEW SECTION. **Section 26. Collateral source services first.** If a collateral source is exempt from
30 subrogation or the obligation to reimburse the health security system as provided in [sections 22 and 87], the

1 department may require that an individual who is entitled to medical services from the source shall first seek those
2 services from that source.

3

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

9

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

14

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

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

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

27 (4) In the event of federal health care reform legislation including payroll, individual income, or cigarette
28 and tobacco products taxation, and to the extent that agreements are reached to transfer that revenue into the
29 health security fund, the legislature may enact a proportional decrease in the payroll, individual income, and
30 cigarette and tobacco taxes established pursuant to [sections 83 through 100] in order that revenue to the health

1 security fund will be maintained within the limits established by [sections 31(1) and 77(3)].

2

3 **NEW SECTION. Section 30. Default.** Default, underpayment, or late payment of any tax or other
4 obligation imposed by [sections 1 through 103] must result in the remedies and penalties provided by law.

5

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

9 (2) (a) If the reserve account is not fully funded, mandatory cost control measures as described in
10 [section 50] must be triggered when the cumulative expenditures of the health security system, on an annualized
11 basis, exceed 95% of the system budget exclusive of the reserve account, except during the last month of the
12 fiscal year.

13 (b) If the reserve account is fully funded and during the last month of the fiscal year, mandatory cost
14 control measures as described in [section 50] must be triggered only when cumulative expenditures of the health
15 security system, on an annualized basis, exceed 100% of the health security system budget exclusive of the
16 reserve account.

17

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

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

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

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

26 (d) a capital expenditure budget, as described in [section 47].

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

29

30 **NEW SECTION. Section 33. System budget.** (1) The cost of the health security system, including the

1 cost of all services and benefits provided, administration, data gathering and other activities, and revenue
2 deposited pursuant to [section 76], comprise the system budget.

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

5

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

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

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

15

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

19 (a) fee-for-service providers;

20 (b) capitated providers; and

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

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

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

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

4 (5) Each health care facility in a system region, apart from those that are part of capitated integrated
5 delivery systems, must have a facility budget that encompasses all operating expenses for the health care facility.
6 In establishing a facility budget, the department shall develop and use separate formulas that reflect the
7 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 through
10 38], the department shall consider anticipated increased expenditures and savings, including but not limited to
11 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 buyer;

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

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

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

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

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

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

25

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

1

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

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

9

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

- 13 (a) submit all bills pursuant to procedures established by the department;
14 (b) not charge the system an amount in excess of rates negotiated or set by the department;
15 (c) not charge the patient any additional amount or copayment except as specified under [sections 11
16 and 65] and by rule.

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

20

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

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

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

30 (4) Any surplus that a health care facility may be able to generate through increased efficiency of

1 operation may be used to develop new and innovative programs, as approved by the department, or must be
2 returned to the health security system.

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

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

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

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

17 (b) A health care facility that fails to provide full access to all individuals pursuant to subsection (7)(a)
18 must be investigated by the department and may be barred from receiving health security system funds in
19 subsequent years, at the discretion of the department, subject to the review procedures in [section 68].

20

21 **NEW SECTION. Section 41. Payment mechanisms.** (1) Physicians, advanced practice nurses, and
22 other independent professional providers may choose from a variety of payment mechanisms for reimbursement.
23 These payment methods may include but need not be restricted to fee-for-service, capitation, or a salary from
24 a globally budgeted health care facility for a defined level of service. [Sections 1 through 82, 101, 103, and 104]
25 may not be construed to permit discrimination in eligibility for reimbursement against a class of professional
26 providers who are providing services within the scope of practice permitted by law.

27 (2) The department may require that all care under fee-for-service payment be coordinated by a
28 designated primary care provider and that all individuals select a primary care provider. The primary care
29 provider may be an individual professional provider or a group of professional providers. Under these
30 arrangements, care provided by specialists without referral from a designated primary care provider must be

1 reimbursed at the primary care rate rather than that for specialty care.

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

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

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

19

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

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

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

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

1

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

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

9

10 **NEW SECTION. Section 44. Integrated delivery systems allowed.** (1) (a) A health care facility and
11 a group of physicians and other professional providers may organize as an integrated delivery system providing
12 the full spectrum of health care services to a defined population of enrollees. An integrated system may be paid
13 by the health security system on a capitated basis to provide the full spectrum of benefits covered by the health
14 security system. [Sections 1 through 82, 101, 103, and 104] may not prevent an integrated delivery system from
15 offering benefits beyond those set forth in [sections 9 through 14]. The fee level for capitated reimbursement
16 must be negotiated on a regional basis by professional provider associations and the department, based on
17 health risk of enrollees and any other relevant factors, and must apply uniformly to all professional providers in
18 the region.

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

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

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

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

1 (4) [Sections 1 through 82, 101, 103, and 104] may not prevent the department, after public hearings,
2 from termination of the participation of a health care facility in the health security system if credible evidence leads
3 the department to conclude either of the following:

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

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

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

11

12 **NEW SECTION. Section 45. Voluntary enrollment under capitated payment arrangements.** (1)

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

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

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

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

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

29 (6) Providers accepting payment from the health security system on a prepaid basis, as a condition of
30 approval to participate in the provision of benefits under [sections 1 through 82, 101, 103, and 104], shall

1 demonstrate that they will provide or arrange and pay for all of the benefits required for the capitation payment
2 negotiated or set by the department.

3 (7) [Sections 1 through 82, 101, 103, and 104] may not prohibit an integrated delivery system or other
4 capitated practice from offering additional benefits beyond those set forth in [sections 9 through 14]. The
5 additional benefits must be clearly set forth in disclosure and practice description materials provided to individuals
6 eligible for services under [sections 1 through 82, 101, 103, and 104].

7

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

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

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

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

23

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

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

1 department.

2 (c) The department shall exclude from any reimbursement under [sections 1 through 82, 101, 103, and
3 104] amounts for capital expenditures, operating expenses for capital improvements, and the cost of services
4 provided by those capital improvements made or incurred by a health care facility or provider after [the effective
5 date of this act], unless that capital expenditure was approved by the department.

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

9 (i) exceeds \$500,000;

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

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

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

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

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

22 (a) fill unmet needs;

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

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

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

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

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

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

3 (h) meet the special needs of rural hospitals.

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

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

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

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

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

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

16

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

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

22 (a) county health care facilities;

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

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

26

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

30

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

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

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

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

7 (2) (a) In the event that the measures taken pursuant to subsection (1) are insufficient to maintain the
8 fiscal integrity of the health security system, the department shall study the contribution of inappropriately
9 provided services to escalating costs. The department shall adjust the next year's budget, pursuant to [sections
10 32 and 36], to correct for the degree of overuse identified for particular services or particular categories of
11 licensed providers under particular modes of reimbursement.

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

16

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

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

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

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

- 1 (a) the diagnosis or the available treatments are often inappropriate; and
2 (b) a means of distinguishing appropriate from inappropriate use of services for the diagnosis is
3 established based on recommendations of the department.

4

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

9

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

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

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

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

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

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

25

26 **NEW SECTION. Section 54. Public health.** (1) The regional health care planning boards shall make
27 recommendations to the department on technology assessment, cost-effectiveness, practice guidelines and
28 standards, and promotion of population-based health strategies with an emphasis on prevention. Funding to
29 carry out these recommendations and to carry out public health research to promote disease prevention
30 strategies must be budgeted from the health security fund in the form of grants for specific programs of the

1 department, other state agencies, county health departments, local governments, or private, nonprofit human
2 services agencies.

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

6

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

10

11 NEW SECTION. **Section 56. Enforcement.** (1) A provider that receives funds or provides care
12 pursuant to [sections 1 through 82, 101, 103, and 104] may not discriminate against a person seeking care on
13 the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition,
14 marital status, sex, sexual orientation, age, wealth, or any other basis prohibited by the civil rights laws of this
15 state. [Sections 1 through 82, 101, 103, and 104] may not require a professional provider, health care facility,
16 or clinic to perform a particular service when either of the following applies:

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

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

21 (2) A person who is eligible for health care services under [sections 1 through 82, 101, 103, and 104] has
22 the right to equitable access of medically appropriate health care and has standing to enforce this section.

23

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

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

1

2 **NEW SECTION. Section 58. Mandatory exclusion of providers.** The department shall exclude the
3 following providers from participation in any program under [sections 1 through 82, 101, 103, and 104]:

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

6 (a) the delivery of an item or service under [sections 1 through 82, 101, 103, and 104] or any other
7 federal or state health care program;

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

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

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

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

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

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

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

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

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

27 (c) is a health maintenance organization or other capitated program and has failed substantially to
28 provide medically necessary items and services that are required under [sections 1 through 82, 101, 103, and
29 104] to be provided to eligible individuals if the failure has adversely affected or has had a substantial likelihood
30 of adversely affecting those individuals;

1 (5) a provider that did not fully or accurately make any disclosure required to be made under [sections
2 1 through 82, 101, 103, and 104]; and

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

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

6 (b) perform the reviews and surveys required by [sections 1 through 82, 101, 103, and 104]; or

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

9

10 **NEW SECTION. Section 59. Discretionary exclusion of providers.** The department may exclude the
11 following providers from participation in any program under [sections 1 through 82, 101, 103, and 104]:

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

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

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

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

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

25 (d) the claim or request for payment is in violation of [sections 1 through 82, 101, 103, and 104] or any
26 regulation issued under [sections 1 through 82, 101, 103, and 104].

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

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

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

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

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

8 (b) This subsection (3) does not apply to any of the following:

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

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

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

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

20

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

27

28 **NEW SECTION. Section 61. Rules for review of exclusion.** (1) The department shall establish
29 regulations and procedures for the review of any action that may result in exclusion or penalties under [sections
30 56 through 63].

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

4 (3) In the case of exclusion, limitation, or penalty for any other reason permitted by [sections 56 through
 5 63], the review procedures must be consistent with [section 69].

6

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

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

10

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

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

16

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

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

21

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

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

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

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

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

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

1 (3) Individuals who receive benefits under the federal medicare program, the civilian health and medical
2 program for the uniformed services, or the federal employees' health benefits plan or who are exempt from
3 copayments under federal law may not be required to make the copayments specified in this section.

4 (4) After the first year of benefits under [sections 1 through 82, 101, 103, and 104], a copayment may
5 not be required for any covered benefit, other than as established by the department pursuant to [section 11].
6 However, the department may extend the period of copayment under subsection (2) of this section for up to 1
7 additional year upon making a finding that the health security system is not yet capable of absorbing the full cost
8 of the benefits.

9

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

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

17

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

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

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

1 in Montana.

2

3 **NEW SECTION. Section 68. Hearings and judicial review.** (1) (a) Any person aggrieved by a
4 decision, order, rate, rule, regulation, action, or failure to act by the department or a regional health care planning
5 board may seek judicial review.

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

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

11 (2) In any action or proceeding challenging a legislative amendment to [sections 1 through 82, 101, 103,
12 and 104], the following apply:

13 (a) The party or parties asserting the validity of the amendment have the burden of proving by clear and
14 convincing evidence that the amendment is consistent with the purposes of [sections 1 through 82, 101, 103, and
15 104]. The purposes of [sections 1 through 82, 101, 103, and 104] include not only the intent, findings, and
16 declarations set forth in [sections 2 and 3] but also include the actions employed to achieve the stated aims.

17 (b) A legislative amendment that is inconsistent with the purposes of [sections 1 through 82, 101, 103,
18 and 104] must be declared invalid, and the prevailing plaintiff, other than the department, an officer, or a member
19 of a department, board, or agency established by [sections 1 through 82, 101, 103, and 104] must be awarded
20 costs and reasonable attorney fees.

21

22 **NEW SECTION. Section 69. Hearings.** (1) Any quasi-judicial hearing required by law must be
23 conducted in accordance with Title 2, chapter 4, except as provided in [sections 1 through 82, 101, 103, and 104].

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

27

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

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

2 (2) The department may establish a uniform notice as described in subsection (1), specifying both content
3 and print size, to be posted at any place of business or included in any advertisement, policy of insurance, or offer
4 to insure. The notice must be limited to an advisement of rights under [sections 1 through 82, 101, 103, and 104]
5 and the name and phone number of a person or office that can provide further information.

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

9

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

12

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

17 (2) Except as provided in [section 39], a participating health care facility or professional provider may
18 provide to any person services or procedures that are not covered benefits under [sections 1 through 82, 101,
19 103, and 104], subject to the following conditions:

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

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

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

29

30 **NEW SECTION. Section 73. Coordination with other laws -- exemption from state and federal**

1 **antitrust laws.** (1) An action taken by or on behalf of the department or by any person as authorized by [sections
2 1 through 82, 101, 103, and 104] may not be considered a violation of unfair trade practices.

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

5 (b) In furtherance of this intent, the legislature finds and declares that it is in the public interest to
6 enhance the ability of professional providers and health care facilities to form bargaining units for the purpose
7 of contracting for the delivery of health care services and that it is in the public interest for the health security
8 system to contract with vendors, professional providers, and health care facilities to further the purposes of
9 [sections 1 through 82, 101, 103, and 104].

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

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

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

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

22 (a) There is a compelling state public interest in each action undertaken by or on behalf of the
23 department and every other state and local agency, board, council, and officer acting under and in furtherance
24 of [sections 1 through 82, 101, 103, and 104], including but not limited to those actions otherwise considered in
25 restraint of trade.

26 (b) [Sections 1 through 82, 101, 103, and 104] prescribe and exercise the degree of state direction and
27 supervision over health care services that provide for state action immunity under federal antitrust laws for
28 activities undertaken by local governmental entities in carrying out their prescribed functions under the health
29 security system.

30 (4) This section does not change existing antitrust law as it relates to any agreement or arrangement to

1 exclude from any of the groups or combinations any person who is lawfully qualified to perform the services to
2 be performed by the members of the group or combination when the ground for the exclusion is failure to possess
3 the same license or certification as is possessed by the members of the group or combination.

4

5 **NEW SECTION. Section 74. Compliance with federal health care reform legislation.** (1) The
6 department shall determine those provisions of [sections 1 through 82, 101, 103, and 104] and those actions
7 taken pursuant to [sections 1 through 82, 101, 103, and 104] that must be modified to achieve compliance with
8 requirements for state health plans as specified by federal laws or regulations, including those enacted after [the
9 effective date of this act].

10 (a) If any statutory provision of [sections 1 through 82, 101, 103, and 104] must be modified to achieve
11 compliance with federal health care reform legislation, the department shall seek appropriate amendment by the
12 legislature, preserving the goals of the health security system, including but not limited to providing universal and
13 comprehensive coverage, cost control, fiscal soundness, and progressive financing.

14 (b) The department shall construe or modify any regulation promulgated under [sections 1 through 82,
15 101, 103, and 104] as necessary to achieve compliance with federal health care reform legislation.

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

19

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

25 (2) The department shall, in all cases, seek to maximize federal contributions and payments for medical
26 care, mental health care, and long-term care services provided in this state, and in obtaining the waivers,
27 exemptions, agreements, or legislation required by subsection (1), the department shall seek to ensure that the
28 contributions of the federal government for medical care, mental health care, and long-term care services in
29 Montana may not decrease in relation to other states as a result of the waivers, exemptions, agreements, or
30 legislation.

1 (3) (a) The department shall pursue all reasonable means to secure repeal or waiver of any provision
2 of federal law that preempts any provision of [sections 1 through 82, 101, 103, and 104].

3 (b) If repeal or waiver cannot be secured, the department shall exercise its powers to promulgate rules
4 or seek conforming state legislation that is consistent with federal law in an effort to best fulfill the purposes of
5 [sections 1 through 82, 101, 103, and 104].

6

7 **NEW SECTION. Section 76. Health security fund account.** (1) There is a health security fund
8 account in the state treasury for the administration and enforcement of [sections 1 through 82, 101, 103, and 104].

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

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

14 (b) The department shall retain the reserve account for budgetary shortfalls in the health security system,
15 for epidemics, or for other extraordinary circumstances as defined by the department and as provided in [section
16 77]. The department's proposed budget must contain funding for the reserve account equal to 1% of the system
17 budget unless the department determines that a different amount is needed for the prudent operation of the health
18 security system.

19

20 **NEW SECTION. Section 77. Appropriations.** (1) It is the intent of the legislature that all money in the
21 health security fund be appropriated to the health security system to support implementation of [sections 1
22 through 82, 101, 103, and 104].

23 (2) The legislature may appropriate additional money from the general fund or from other sources to
24 support the implementation of [sections 1 through 82, 101, 103, and 104].

25 (3) After full phasein of benefits under [sections 9 through 14], if for each of 2 consecutive years the
26 balance remaining in the health security fund at the end of the fiscal year is greater than 1% of the system budget
27 and the reserve account is fully funded, the department shall request that the legislature reduce the tax rates in
28 [sections 83 through 100].

29

30 **NEW SECTION. Section 78. Federal contributions to health security fund.** The department shall

1 seek all necessary waivers, exemptions, agreements, or legislation to allow all current federal payments for health
2 care to be paid directly to the health security system, which shall then assume responsibility for all benefits and
3 services previously paid for by the federal government with those funds. In obtaining the waivers, exemptions,
4 agreements, or legislation, the department shall seek from the federal government a contribution for health care
5 services in Montana that may not decrease in relation to the contribution to other states as a result of the waivers,
6 exemptions, agreements, or legislation.

7

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

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

17

18 **NEW SECTION. Section 80. County and local contributions to health security fund.** The
19 department shall seek all necessary waivers, exemptions, agreements, or legislation to allow all current county
20 or other local agency or local government payments for health care, including employee health benefits and
21 health benefits for retired employees, to be paid directly to the health security system, which shall then assume
22 responsibility for all benefits and services previously paid for by counties or other local agencies or local
23 governments with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the department
24 shall seek contributions for health care services that may not decrease in relation to expenditures for health care
25 services in 1999, corrected for changes in the state gross domestic product and population.

26

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

1

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

7

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

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

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

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

19

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

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

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

26 (2) The amount of a credit provided under this section may not exceed the individual's health security
27 income tax obligation in any year. A credit may not be carried over from year to year.

28

29 **NEW SECTION. Section 85. Employer option.** (1) [Sections 1 through 82, 101, 103, and 104] may
30 not be construed to interfere with an employer choosing to pay, in part or in full, the individual health security

1 income tax for an employee.

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

4

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

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

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

16 (d) A corporate officer of a closely held corporation that meets the stock ownership test under section
17 542(a)(2) of the Internal Revenue Code and receives wages as an employee of the corporation is required to pay
18 the health security tax only on the wages received. The corporation is not liable for the tax on the corporate
19 officer's wages.

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

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

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

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

1 health security fund payroll tax required by this section.

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

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

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

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

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

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

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

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

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

1 (8) [Sections 1 through 82, 101, 103, and 104] may not be construed to prevent an employer from
2 providing health benefits in excess of those available under the health security system.

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

5

6 **NEW SECTION. Section 87. Exempt employers.** (1) An employer is exempt from the payroll tax
7 requirements of [sections 86, 88, and 89] if it has established an employee benefit plan subject to federal law that
8 preempts the funding provisions of [sections 20 through 30, 75(3), 76 through 81, 83, and 86].

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

11 (3) An employer is exempt from any other provisions of [sections 1 through 82, 101, 103, and 104] to
12 the extent compliance with the provision would be preempted by federal law. It is the intent of the legislature that
13 the provisions of [sections 1 through 82, 101, 103, and 104] be construed to be consistent with federal law.

14

15 **NEW SECTION. Section 88. Phasein of employer health security fund payroll tax.** (1) For the first
16 year in which benefits are provided under [sections 1 through 82, 101, 103, and 104], the payroll tax rate is the
17 amount specified in [section 86], adjusted as follows:

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

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

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

27

28 **NEW SECTION. Section 89. Credit against employer health security fund payroll tax.** (1) With
29 respect to each employee affected, an employer who on [the effective date of this act] was under a contractual
30 or legal obligation to provide the employee with health care benefits, which are covered benefits under the health

1 security system, or to pay for benefits through a policy of insurance or otherwise, must receive a credit against
2 its payroll tax obligation in a tax period equal to the amount it pays during that period for the benefits or insurance
3 pursuant to the contract or legal obligation.

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

6 (3) Subsection (1) may not apply to obligations subject to federal preemption as described in [sections
7 21, 75(3), and 87].

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

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

14 (5) A credit may not be carried over from year to year or transferred among employees.
15

16 **NEW SECTION. Section 90. Corporate income health security fund surtax.** After the amount of tax
17 liability has been computed under 15-31-121(1) through (3), each corporation subject to taxation under Title 15,
18 chapter 31, part 1, shall add a health security fund surtax of 6 3/4%. Revenue from this section must, in
19 accordance with 15-1-501, be deposited to the credit of the health security fund account established in [section
20 76].
21

22 **NEW SECTION. Section 91. Health security fund cigarette tax.** There is imposed a health security
23 fund tax, in addition to the tax imposed in 16-11-111, of 18 cents on each package containing 20 cigarettes, and
24 for packages containing more or less than 20 cigarettes, a tax on each cigarette equal to 1/20th the tax on a
25 package containing 20 cigarettes is imposed. Revenue from this section must, in accordance with 15-1-501, be
26 deposited to the credit of the health security fund account established in [section 76]. The tax in this section is
27 subject to 16-11-111(2) through (6).
28

29 **NEW SECTION. Section 92. Health security fund tobacco products tax.** There is imposed a health
30 security fund tax, in addition to the tax in 16-11-202, of 12 1/2% of the wholesale price of tobacco products other

1 than cigarettes sold or possessed in this state, excepting from the tax tobacco products shipped from Montana
2 and destined for retail sale and consumption outside the state. Revenue from this section must, in accordance
3 with 15-1-501, be deposited to the credit of the health security fund account established in [section 76].

4

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

12

13 **NEW SECTION. Section 94. Health security fund tax on liquor.** In addition to the excise tax provided
14 for in 16-1-401 and the license tax provided for in 16-1-404, the department shall collect at the time of sale and
15 delivery of any liquor under any provisions of the laws of the state a health security fund tax of 16% of the retail
16 selling price on all liquor sold and delivered in the state. Revenue from this section must, in accordance with
17 15-1-501, be deposited to the credit of the health security fund account established in [section 76].

18

19 **NEW SECTION. Section 95. Health security fund tax on table wine and hard cider.** (1) In addition
20 to the tax levied in 16-1-411, a health security fund tax of 27 cents per liter is imposed on table wine imported by
21 a table wine distributor or the department. A tax of 3.7 cents per liter is imposed on hard cider imported by a table
22 wine distributor or the department.

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

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

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

30

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

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

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

9

10 **NEW SECTION. Section 97. Health security fund tax on oil and gas production.** Each person
 11 engaging in or carrying on the business of producing petroleum, other mineral or crude oil, or natural gas within
 12 this state or engaging in or carrying on the business of owning, controlling, managing, leasing, or operating within
 13 this state any well or wells from which any merchantable or marketable petroleum, other mineral or crude oil, or
 14 natural gas is extracted or produced shall for each year when engaged in or carrying on the business in this state
 15 pay to the department of revenue for deposit in the health security fund account established in [section 76], in
 16 accordance with 15-1-501, a health security fund tax of 5% on the gross taxable value of all the petroleum, other
 17 mineral or crude oil, or natural gas produced by the person.

18

19 **NEW SECTION. Section 98. Health security fund tax on metalliferous mines.** In addition to the tax
 20 provided for in 15-37-103, the annual health security fund tax to be paid by a person engaged in or carrying on
 21 the business of working or operating any mine or mining property in the state from which gold, silver, copper,
 22 lead, or any other metal or metals or precious or semiprecious gems or stones are produced is 1.85% computed
 23 on the gross value of product that may have been derived by the person from the mining business, work, or
 24 operation within this state during the calendar year immediately preceding. Proceeds must be deposited in the
 25 health security fund account established in [section 76].

26

27 **NEW SECTION. Section 99. Health security fund tax on video gambling machine gross income.**
 28 There is imposed upon each licensed operator who is issued a permit under Title 23, chapter 5, part 6, a health
 29 security fund tax of 15% of the gross income from each video gambling machine licensed under Title 23, chapter
 30 5, part 6. Revenue from this section must, in accordance with 15-1-501, be deposited to the credit of the health

1 security fund account established in [section 76].

2

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

7

8 **NEW SECTION. Section 101. Legislative amendment.** (1) The provisions of [sections 1 through 82,
9 101, 103, and 104] may not be amended except to further its purposes by a statute passed by a vote of two-thirds
10 of each house or upon approval by the electorate.

11 (2) The two-thirds vote requirement of subsection (1) does not apply to any provision of [sections 1
12 through 82, 101, 103, and 104] that meets any of the following requirements:

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

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

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

19

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

21 **"15-1-501. Disposition of money from certain designated license and other taxes.** (1) The state
22 treasurer shall deposit to the credit of the state general fund in accordance with the provisions of subsection (3)
23 all money received from the collection of:

24 (a) income taxes, interest, and penalties collected under chapter 30;

25 (b) except as provided in 15-31-702, all taxes, interest, and penalties collected under chapter 31;

26 (c) oil and natural gas production taxes allocated under 15-36-324(8)(a) and (10)(a);

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

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

29 (f) liquor license taxes under Title 16;

30 (g) fees from driver's licenses, motorcycle endorsements, and duplicate driver's licenses as provided

1 in 61-5-121;

2 (h) inheritance and estate taxes under Title 72, chapter 16; and

3 (i) fees based on the value of currency on deposit and tangible personal property held for safekeeping
4 by a foreign capital depository as provided in 15-31-803.

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

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

12 (4) All refunds of taxes must be attributed to the funds in which the taxes are currently being recorded.
13 All refunds of interest and penalties must be attributed to the funds in which the interest and penalties are
14 currently being recorded.

15 (5) This section does not apply to taxes collected under [sections 83 through 100]."

16

17 **NEW SECTION. Section 103. Insurance provisions not applicable.** The provisions of Title 33 do not
18 apply to [sections 1 through 82, 101, and 104 and this section].

19

20 **NEW SECTION. Section 104. Construction.** [Sections 1 through 82, 101, 105 and this section] must
21 be construed as necessary to comply with federal health care legislation, consistent with the intent of [sections
22 1 through 82, 101, 105 and this section] to establish a single payor for health care with freedom of choice of
23 professional providers and a single standard of care for all Montanans eligible for particular services under the
24 health security system.

25

26 **NEW SECTION. Section 105. Codification instructions.** (1) [Sections 1 through 82, 101, 103, and
27 104] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter
28 4, apply to [sections 1 through 82, 101, 103, and 104].

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

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

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

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

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

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

11 (8) [Section 97] is intended to be codified as an integral part of Title 15, chapter 36, part 3, and the
12 provisions of Title 15, chapter 36, part 3, apply to [section 97].

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

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

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

19

20 **NEW SECTION. Section 106. Severability.** If a part of [this act] is invalid, all valid parts that are
21 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,
22 the part remains in effect in all valid applications that are severable from the invalid applications.

23

24 **NEW SECTION. Section 107. Contingent suspension -- voidness.** (1) If Constitutional Initiative No.
25 75, enacting Article VIII, section 17, of the Montana constitution, has not been declared invalid as of [the effective
26 date of this act], then [sections 1 through 106] are suspended until such time as Constitutional Initiative No. 75
27 may be declared invalid.

28 (2) If Article VIII, section 17, of the Montana constitution remains in effect as of the commencement of
29 the 57th legislature, it is the intent of the 56th legislature that the provisions of [sections 83 through 100] that may
30 be subject to voter approval under Article VIII, section 17, be submitted to the voters at an appropriate tax

1 election.

2 (3) If the tax increases provided in [sections 83 through 100] are submitted to and not approved by the
3 electorate as provided in subsection (2), then [this act] is void.

4 - END -

