SENATE BILL NO. 474

INTRODUCED BY F. THOMAS, R. BROWN, BRUEGGEMAN, COCCHIARELLA, FORRESTER, GALLUS, GILLAN, GOLIE, KEANE, KEENAN, LASZLOFFY, MANGAN, MCCARTHY, MOOD, NELSON, PEASE, ROUSH, D. RYAN, SHEA, STAPLETON

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE MONTANA GOLD SENIOR PHARMACY PROGRAM TO PROVIDE A PRIVATE SECTOR, INSURANCE-BASED DRUG BENEFIT TO ELIGIBLE SENIOR CITIZENS; PROVIDING ELIGIBILITY CRITERIA; PROVIDING LIMITS ON THE BENEFIT AMOUNT PROVIDED BY THE PROGRAM; ESTABLISHING AN ACCOUNT IN THE STATE TREASURY FOR THE PROGRAM; REQUIRING A REQUEST FOR PROPOSALS FROM HEALTH INSURERS FOR ADMINISTERING THE PROGRAM; PROVIDING FOR FUNDING THE PROGRAM USING TOBACCO SETTLEMENT TRUST FUND MONEY THROUGH A TRANSFER FROM THE TRUST FUND TO THE ACCOUNT; AMENDING SECTIONS 33-1-102, 33-22-113, 33-22-302, 33-22-903, AND 33-22-1521, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Montana gold senior pharmacy program.** There is a Montana gold senior pharmacy program. The purpose of the program is to provide a private sector, insurance-based drug benefit to eligible senior citizens.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 7], the following definitions apply:

(1) "Account" means the Montana gold senior pharmacy program account established in [section 3].

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

(3) "Household income" means the income received by a claimant and the spouse of the claimant.

(4) "Income" means adjusted gross income, as defined in the Internal Revenue Code~~, and~~. THE TERM includes THE FOLLOWING ITEMS THAT THE DEPARTMENT MAY CONSIDER:

(a) tax-free interest;

(b) the untaxed portion of a pension or annuity;

(c) railroad retirement benefits;

(d) veterans' pensions and compensation;

(e) payments received pursuant to the federal Social Security Act, including supplemental security income but excluding hospital and medical insurance benefits for the aged and disabled;

(f) public welfare payments, including allowances for shelter;

(g) unemployment insurance benefits;

(h) payments for lost time;

(i) payments received from disability insurance;

(j) disability payments received pursuant to workers' compensation insurance;

(k) maintenance payments pursuant to a dissolution of marriage decree;

(l) support payments;

(m) allowances received by dependents of military personnel;

(n) the amount of recognized capital gains and losses excluded from adjusted gross income;

(o) life insurance proceeds in excess of $5,000;

(p) bequests and inheritances; and

(q) gifts of cash of more than $300 not between household members and other kinds of cash received by a household as the department specifies by rule.

(5) "Senior citizen" means a person who is domiciled in this state and who is 65 years of age or older.

NEW SECTION. **Section 3. Powers and duties of department -- account.** (1) The department is responsible for the administration of the provisions of [sections 1 through 7]. The department may:

(a) prescribe the content and form of an application for participation in the program required to be submitted pursuant to [section 6];

(b) designate the proof that must be submitted with an application for a benefit;

(c) adopt rules to protect the confidentiality of information supplied by a senior citizen applying for participation in the program pursuant to [section 6]; and

(d) adopt other rules that are necessary to carry out the provisions of [sections 1 through 7]. THE RULES MAY PROVIDE FOR REINSURANCE PURSUANT TO TITLE 33, CHAPTER 2, PART 12, AND FOR A PHARMACY BENEFITS MANAGER.

(2) The department shall enter into a contract with a private insurer to offer the prescription drug coverage available under [sections 1 through 7]. THE PRIVATE INSURER MUST BE LICENSED TO DO BUSINESS IN MONTANA AND IS SUBJECT TO REGULATION UNDER TITLE 33. The contract must include a provision allowing all

Montana pharmacies to participate in the program.

(3) There is a Montana gold senior pharmacy program account in the state special revenue fund. The department shall deposit in the account the fees received under [section 5] and legislative appropriations and fund transfers for the program. The money in the account may be used only for the purposes of [sections 1 through 7], including subsidizing the cost of insurance, including premiums, under the contract provided for in subsection (2) of this section.

NEW SECTION. **Section 4. Cooperation between state and local agencies.** The department shall, in cooperation with the department of revenue and the counties in this state:

(1) combine all possible administrative procedures required for determining those persons who are eligible for assistance pursuant to [section 5];

(2) coordinate the collection of information required to carry out the provisions of [sections 1 through 7] in a manner that requires persons applying for assistance to furnish information in as few reports as possible; and

(3) design forms that may be used jointly by the department of public health and human services, the department of revenue, and the counties in this state to carry out the provisions of [sections 1 through 7].

NEW SECTION. **Section 5. Program -- eligibility -- costs -- coverage -- change of eligibility.** (1) The department shall, within the limits of the money available for this purpose in the account, develop and carry out a program to provide prescription drugs and pharmaceutical services to senior citizens at a reduced cost. Under the program, the insurer will pay the difference between the copayment required by the program and the actual ~~retail~~ cost of the drug from the pharmacist. THE RATES NEGOTIATED BY THE DEPARTMENT OR ITS REPRESENTATIVE FOR THE PRESCRIPTION DRUGS SOLD BY THE PHARMACIES THAT AGREE TO PARTICIPATE IN THIS PROGRAM MAY NOT BE MORE THAN THE RATES CHARGED TO THE DEPARTMENT UNDER THE STATE PLAN FOR MEDICAID. The department shall pay the amount of the benefit directly to an insurer through the contract pursuant to [sections 1 through 7].

(2) Within the limits of the money available, a senior citizen who is not eligible for medicaid and who is accepted into the program that is made available pursuant to subsection (1) is entitled to an annual benefit amount from the account to subsidize a portion of the cost of prescription drugs and pharmaceutical services if the senior citizen ~~has been~~ IS domiciled in this state ~~for at least 1 year immediately preceding~~ ON the date of the senior citizen's application and if the senior citizen's household income is less than 199% of the federal poverty level. The annual ~~benefit~~ PREMIUM amount must be based upon the following scale:

(a) for a single individual whose household income is:

(i) between 75% of the federal poverty level and ~~99%~~ 129% of the federal poverty level, 100% of the ~~base benefit~~ PREMIUM AMOUNT;

(ii) between ~~100%~~ 130% of the federal poverty level and ~~124%~~ 174% of the federal poverty level, ~~90% of the base benefit~~ 80% OF THE PREMIUM AMOUNT;

(iii) between ~~125%~~ 175% of the federal poverty level and ~~129%~~ 199% of the federal poverty level, ~~80% of the base benefit;~~

~~(iv) between 130% of the federal poverty level and 149% of the federal poverty level, 70% of the base benefit;~~

~~(v) between 150% of the federal poverty level and 174% of the federal poverty level, 60% of the base benefit;~~

~~(vi) between 175% of the federal poverty level and 184% of the federal poverty level, 50% of the base benefit;~~

~~(vii) between 185% of the federal poverty level and 199% of the federal poverty level, 40% of the base benefit~~ 60% OF THE PREMIUM AMOUNT.

(b) for a household of two or more individuals whose household income is:

(i) between 75% of the federal poverty level and ~~99%~~ 129% of the federal poverty level, 100% of the ~~base benefit~~ PREMIUM AMOUNT;

(ii) between ~~100%~~ 130% of the federal poverty level and ~~124%~~ 174% of the federal poverty level, ~~90% of the base benefit~~ 80% OF THE PREMIUM AMOUNT;

(iii) between ~~125%~~ 175% of the federal poverty level and ~~129%~~ 199% of the federal poverty level, ~~80% of the base benefit;~~

~~(iv) between 130% of the federal poverty level and 149% of the federal poverty level, 70% of the base benefit;~~

~~(v) between 150% of the federal poverty level and 174% of the federal poverty level, 60% of the base benefit;~~

~~(vi) between 175% of the federal poverty level and 184% of the federal poverty level, 50% of the base benefit;~~

~~(vii) between 185% of the federal poverty level and 199% of the federal poverty level, 40% of the base benefit~~ 60% OF THE PREMIUM AMOUNT.

(3) The department may pay its costs for administering this program from the account and shall include as components of the program:

(a) a maximum annual application fee of $25;

(b) a requirement that a generic drug be used to fill the prescription unless the substitution of a generic drug for a drug with a brand name is specifically prohibited by the health care provider who issued the prescription;

(c) a maximum required copayment for generic drugs of $10 for each prescription;

(d) a maximum required copayment for nongeneric drugs of $25 for each prescription;

(e) the maximum limitation of $5,000 per year as the ~~base~~ benefit that each person may receive under this program;

(f) a maximum of $100 as the amount of deductible expenses that may be required of participants before they are eligible to receive benefits under this program; and

(g) if considered advisable and fiscally prudent by the department, the hiring of a pharmacy benefits manager by contract to assist in the development of this program.

(4) If the federal government provides any coverage of prescription drugs and pharmaceutical services for senior citizens who are eligible to participate in the program pursuant to subsections (1) through (3), the department may, within the limits of the money available for this purpose in the account, provide assistance with prescription drugs and pharmaceutical services for senior citizens under the federal program.

(5) The department shall request any federal waivers necessary in order to maximize federal financial participation in the program. THE DEPARTMENT MAY NOT IMPLEMENT THE PROGRAM WHILE AN APPLICATION FOR A FEDERAL WAIVER IS PENDING. THE DEPARTMENT SHALL IMPLEMENT THE PROGRAM UPON APPROVAL OF A FEDERAL WAIVER. IF A FEDERAL WAIVER IS DENIED, THE DEPARTMENT SHALL IMPLEMENT THE PROGRAM USING AVAILABLE STATE FUNDS.

~~(5)~~(6) The provisions of subsections (1) through (3) do not apply if the department provides assistance with prescription drugs and pharmaceutical services for senior citizens pursuant to subsection (4).

~~(6)~~(7) (a) When considering the applicant's current financial circumstances, the department may waive the eligibility requirement set forth in subsection (2) regarding household income upon written request of the applicant if the circumstances of the applicant's household have changed as a result of:

(i) illness;

(ii) disability; or

(iii) extreme financial hardship based on a significant reduction of income.

(b) An applicant who requests a waiver under subsection ~~(6)(a)~~ (7)(A) shall include with that request all medical and financial documents that support the request.

~~(7)~~(8) The program must contain a provision prohibiting requiring or requesting that a physician switch from a medication previously used by the senior citizen to another medication based primarily on economic considerations as a condition of receiving a benefit or the prompt refill of a prescription.

NEW SECTION. **Section 6. Request for benefits -- action on application -- payment.** (1) A senior citizen who wishes to receive a benefit pursuant to [sections 1 through 7] shall file an application with the department. The applications must be available at participating pharmacies.

(2) The application must be made under oath and filed in a form and content, accompanied by proof, that the department may prescribe.

(3) The department shall, within 45 days after receiving an application for a benefit, examine the application and grant or deny it.

(4) The department shall determine which senior citizens are eligible to receive a benefit pursuant to [sections 1 through 7] and shall provide the benefit through the insurer in the manner set forth in the program.

NEW SECTION. **Section 7. Denial of request -- repayment of fraudulent payments.** (1) The department shall deny any application for a benefit to which the senior citizen is not entitled. A senior citizen whose application is denied may appeal the decision pursuant to the contested case procedure provided for in Title 2, chapter 4, part 6.

(2) The department may deny in total any application that it finds to have been filed with fraudulent intent. If a benefit based upon a fraudulent application has been paid and is subsequently denied, the amount of the benefit must be repaid by the senior citizen to the department.

(3) Any amounts received by the department pursuant to this section must be deposited with the state treasurer in the account.

NEW SECTION. **Section 8. Request for proposals.** The department of public health and human services shall request proposals for offering a drug-only benefit for eligible senior citizens. The request for proposals must be based upon the provisions of [sections 1 through 7]. The request for proposals may include appropriate provisions from the revised request for proposals created by the state of Nevada to implement a similar program.

Section 9. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs -- service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations or to managed care community networks, as defined in 53-6-702, to the extent that the existence and operations of those organizations are governed by chapter 31 or to the extent that the existence and operations of those networks are governed by [sections [1 through 7] or Title 53, chapter 6, part 7. The department of public health and human services is responsible to protect the interests of consumers by providing complaint, appeal, and grievance procedures relating to managed care community networks and health maintenance organizations under contract to provide services under [sections 1 through 7] or Title 53, chapter 6.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under [sections 1 through 7] and Title 53 that are provided under contract by entities subject to this title. The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) This code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) This code does not apply to any arrangement, plan, or interlocal agreement between political

subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract.

(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling. A service contract does not include motor club service as defined in 61-12-301.

(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code."

Section 10. Section 33-22-113, MCA, is amended to read:

"33-22-113. Disability insurance coverage of persons eligible for public medical assistance. ~~No~~ A disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state ~~on or after July 1, 1979,~~ may not contain any provision denying or reducing ~~such~~ benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2. This section does not apply to pharmacy benefits provided under [sections 1 through 7]."

Section 11. Section 33-22-302, MCA, is amended to read:

"33-22-302. Age limits -- effect on coverage. If ~~any such~~ a disability insurance policy or certificate contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if ~~such~~ that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after ~~such~~ that date, the coverage provided by the policy will continue in force

subject to any right of cancellation until the end of the period for which premium has been accepted. ~~In the event~~ If the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of ~~such~~ the premium or premiums, then the liability of the insurer ~~shall be~~ is limited to the refund, upon request, of all premiums paid for the period not covered by the policy. This section does not apply to a policy issued under [sections 1 through 7]."

Section 12. Section 33-22-903, MCA, is amended to read:

"33-22-903. Definitions. As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) (a) "Health care expenses"~~:~~

~~(a)~~ means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer~~;~~.

(b) The term does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) (a) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under 42

U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

(b) The term does not include:

~~(a)~~(i) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; ~~or~~

~~(b)~~(ii) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981; or

(iii) policies issued pursuant to [sections 1 through 7].

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 13. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. Association plan -- minimum benefits. A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting 33-22-701 through 33-22-705), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but the maximums may not be less than $100,000.

(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of at least $500,000.

(c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is provided.

(d) The board may authorize other association plans, including managed care plans as defined in 33-36-103.

(2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional and when designated in the contract:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental;

(l) services of a licensed home health agency, up to a maximum of 180 visits per year;

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $2,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year;

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patients medical condition when approved in advance by the insurer; and

(w) coverage for severe mental illness as required in 33-22-706.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) home and office calls, except as specifically provided in subsection (2);

(ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(iii) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(iv) oral surgery, except as specifically provided in subsection (2);

(v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the service is provided; or

(vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, except as provided by subsection (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) room and board for a nonemergency admission on Friday or Saturday;

(vii) routine well baby care;

(viii) complications to a newborn, unless no other source of coverage is available;

(ix) reversal of sterilization;

(x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xi) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xii) artificial insemination or treatment for infertility; ~~or~~

(xiii) breast augmentation or reduction; or

(xiv) prescription drugs covered under [sections 1 through 7]."

NEW SECTION. **Section 14. Fund transfer.** The amount of $7.5 million is transferred from the tobacco settlement trust fund established in Article XII, section 4, of the Montana constitution to the Montana gold senior pharmacy program account established in [section 3] DURING EACH FISCAL YEAR OF THE BIENNIUM BEGINNING JULY 1, 2003. The director of the department of public health and human services may request the transfer of specific amounts within this limit as needed to implement the program.

NEW SECTION. **Section 15. Codification instruction.** [Sections 1 through 7] are intended to be codified as an integral part of Title 52, chapter 3, and the provisions of Title 52, chapter 3, apply to [sections 1 through 7].

NEW SECTION. **Section 16. Two-thirds vote.** Because [section 14] authorizes the expenditure of money from the principal of the Montana tobacco settlement trust fund, Article XII, section 4, of the Montana constitution requires a vote of two-thirds of the members of each house of the legislature for passage.

NEW SECTION. **Section 17. Effective date.** [This act] is effective July 1, 2003.

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