HOUSE BILL NO. 623

INTRODUCED BY L. BANGERTER

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO HEALTH CARE AND HEALTH INSURANCE TO IMPROVE ACCESS WITHOUT EXPANDING THE MEDICAID PROGRAM AS ALLOWED UNDER PUBLIC LAW 111-148 AND PUBLIC LAW 111-152; ESTABLISHING A CITIZENS COUNCIL ON HEALTH CARE REFORM; PROVIDING GRANTS TO ASSIST CERTAIN INDIVIDUALS WITH THE PURCHASE OF HEALTH INSURANCE; ESTABLISHING PRACTICE REQUIREMENTS FOR WWAMI GRADUATES; REVISING THE DISTRIBUTION OF PROCEEDS FROM A CONVERSION TRANSACTION OF A NONPROFIT HEALTH ENTITY; CREATING A SPECIAL REVENUE ACCOUNT; PROVIDING DEFINITIONS; PROVIDING A STATUTORY APPROPRIATION AND AN APPROPRIATION; AMENDING SECTIONS 17-7-502, 50-4-716, AND 50-4-720, MCA; AND PROVIDING EFFECTIVE DATES, APPLICABILITY DATES, AND A TERMINATION DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 8] may be cited as the "Roadmap to a Healthier Montana Act".

NEW SECTION. **Section 2. Legislative findings and intent.** (1) The intent of [sections 1 through 8] is to modify and enhance Montana's health care delivery system to provide access to quality and affordable health care for Montana citizens.

(2) The legislature finds that in order to achieve the purposes of [sections 1 through 8], state government, health care providers, patient advocates, and other parties interested in quality and affordable health care must collaborate in order to:

(a) increase the number of Montanans with health insurance coverage;

(b) provide greater value for the tax dollars spent on the medicaid program by exploring options for delivering services in a more efficient and cost-effective manner, including but not limited to:

(i) offering incentives to encourage health care providers to achieve measurable performance outcomes;

(ii) improving the coordination of care among health care providers and health care payers;

(iii) reducing preventable hospital readmissions; and

(iv) exploring medicaid payment methodologies that promote quality of care and efficiencies;

(c) contain growth in health care costs by:

(i) curbing wasteful spending;

(ii) avoiding unnecessary use of health care services;

(iii) reducing the instances in which health care practitioners provide health care services in order to avoid the risk of litigation; and

(iv) reducing fraud;

(d) ensure that there is an adequate supply of health care professionals throughout the state;

(e) provide incentives that result in Montanans taking greater responsibility for their personal health;

(f) boost Montana's economy by reducing the costs of uncompensated care; and

(g) reduce or minimize the shifting of payment for unreimbursed health care costs to patients with private insurance.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 8], the following definitions apply:

(1) "Council" means the citizens council on health care reform provided for in [section 4].

(2) "Department" means the department of public health and human services provided for in 2-15-2201.

(3) "Resident" means an individual who meets the requirements of 1-1-215.

NEW SECTION. **Section 4. Citizens council on health care reform -- membership -- compensation -- meetings.** (1) There is a citizens council on health care reform made up of members of the legislature and of Montana citizens.

(2) (a) The council consists of 12 members appointed as follows:

(i) three members who served in the senate during the 63rd legislative session, two of whom are appointed by the president of the senate and one of whom is appointed by the senate minority leader;

(ii) three members who served in the house of representatives during the 63rd legislative session, two of whom are appointed by speaker of the house of representatives and one of whom is appointed by the house minority leader; and

(iii) six members of the public appointed by the speaker of the house of representatives.

(b) The public members must be selected as follows:

(i) one member of the executive branch, appointed from a list submitted by the governor of individuals who are familiar with the state medicaid program and with health policy matters;

(ii) one member of the state auditor's office, appointed from a list of individuals submitted by the state auditor;

(iii) one member of the health insurance industry;

(iv) one member of the public;

(v) one representative of a critical access hospital as defined in 50-5-101; and

(vi) one representative of a hospital as defined in 50-5-101.

(c) Appointments must be made before May 30, 2013.

(3) (a) A vacancy that occurs when the legislature is not in session must be filled by the person who made the original appointment.

(b) A legislative member shall serve until the member's term of office as a legislator ends or until a successor is appointed, whichever occurs first. A person appointed to replace a legislative member of the council must be from the same house and political party as the member whose vacancy is being filled.

(4) (a) The speaker of the house of representatives shall appoint the presiding officer of the council. The president of the senate shall appoint the vice presiding officer.

(b) The presiding officer and vice presiding officer may not be from the same political party.

(5) The presiding officer shall establish the meeting schedule. The council may meet during legislative sessions.

(6) Members are entitled to receive compensation and expenses as provided in 5-2-302.

(7) The legislative services division shall provide staff assistance to the council. The council may request that personnel from state agencies and from political subdivisions furnish information and provide assistance.

(8) The council may contract for services that will assist members in carrying out their duties under [section 5], subject to available funding and in accordance with the provisions of Title 18, chapter 4.

NEW SECTION. **Section 5. Council duties.** (1) The council shall examine:

(a) longer-term reforms to the ways in which health care services are delivered in Montana;

(b) activities related to the Montana medicaid program and ways to make the program more efficient and cost-effective; and

(c) options for global cost containment, including but not limited to efforts being undertaken in other states and the feasibility of using incentives to encourage cost-containment efforts.

(2) The council's review of the health care delivery system may include but is not limited to:

(a) using medical homes and coordinated care organizations;

(b) reducing or minimizing the shifting of the payment of unreimbursed health care costs to patients with private insurance;

(c) providing incentives for encouraging health care providers to meet identified and measurable benchmarks in the delivery of health care services;

(d) reducing inappropriate use of emergency department services, including ways to monitor for excessive and inappropriate use of prescription drugs;

(e) promoting the appropriate use of health care services, particularly laboratory and diagnostic imaging services;

(f) increasing the availability of mental health services; and

(g) improving the sharing of data among health care providers in order to identify patterns in the usage of health care services across payment sources.

(3) The council's review of the medicaid program may include but is not limited to:

(a) considering the fiscal soundness and efficiency of the program and recommending principles of sound fiscal and public policy as guidelines for innovation in and sustainability of the current medicaid program;

(b) proposing legislation to keep the medicaid program within the guidelines of sound public policy;

(c) reviewing and recommending to the legislature whether the state should pursue federal waiver authority in order to meet public policy guidelines at a lower fiscal impact;

(d) examining ways to improve patient outcomes, including appropriate goals for patient outcomes and ways to measure outcomes;

(e) reviewing the potential for use of a managed care model for the medicaid program as a way to control costs;

(f) evaluating whether significant structural reforms could reverse the trend of increasing medicaid costs without reducing current eligibility standards;

(g) examining ways to reduce fraud and waste; and

(h) examining ways in which to reform the delivery of medicaid services.

(4) The council shall develop recommendations that address the following items:

(a) whether new payment methods have the potential to reduce costs to the state;

(b) a long-term sustainable financing model;

(c) new delivery models that support quality care and cost control; and

(d) an analysis of methods of increasing pricing transparency and equitable patient access in the system.

(5) The council shall examine information about the effects of allowing market-based approaches in providing services to medicaid recipients, including but not limited to:

(a) customized benefit packages;

(b) enhanced benefits for participating in healthy behaviors; and

(c) risk-adjusted premiums based on enrollee health status.

(6) (a) The council shall solicit proposed statutory changes to the state's medicaid program from council members, legislators, medicaid providers, advocacy organizations, and other interested parties. The council shall review the proposals and report to the legislature on each proposal. The report must include but is not limited to:

(i) a summary of the fiscal and public policy implications of the proposal;

(ii) an analysis of the effect of the proposal on the state's general fund, including potential impacts on the amount of money available for other programs;

(iii) an analysis of the soundness of the proposal as a matter of public policy;

(iv) any amendments proposed by the council; and

(v) the council's recommendation on whether the proposal should be enacted by the legislature.

(b) The council's report must be attached to any proposal that the council considered and that is or has been introduced as a bill during a legislative session.

(7) The council shall review activities the department is undertaking to carry out the education and outreach requirements of [section 6] and make recommendations to the department on activities that may be included in those efforts.

(8) (a) The council shall adopt a study plan by a majority vote of the council. The plan may be amended by majority vote.

(b) The plan may specify the date by which proposals affecting the medicaid program must be submitted to the council.

(9) The council shall submit a report of its findings and recommendations to the governor and to the legislature and shall report on its activities to legislative interim committees as requested.

NEW SECTION. **Section 6. Education and outreach on insurance coverage options.** (1) The department shall undertake activities to increase public awareness of and knowledge about the options for obtaining health insurance coverage, including but not limited to the availability of federal tax credits for purchasing insurance, the availability of the state income-enhancement grants provided for in [section 7], and the ways in which the health exchange may be used to review and decide on insurance options.

(2) The department shall report on its plans and activities under this section to legislative committees as required by law or requested by a committee.

NEW SECTION. **Section 7. Income-enhancement grant program -- eligibility -- purpose of grants -- rulemaking.** (1) The department shall provide a grant of $1,000 to an individual meeting the requirements of this section. The grants must be:

(a) considered income for the purposes of purchasing a qualified health plan as defined in 42 U.S.C. 18021(a); and

(b) used as provided in subsection (6).

(2) An individual may qualify for a grant under this section if the individual is not eligible for the medicaid program provided for in Title 53, chapter 6, part 1, and the individual:

(a) is the primary caregiver for a dependent child;

(b) has resources of less than $3,000 as established by the department by rule; and

(c) has an income of less than 100% of the federal poverty level because the individual:

(i) has a serious physical or mental health condition; or

(ii) is the primary caregiver for an immediate family member who is disabled as defined in 42 U.S.C. 1382c.

(3) An applicant shall provide documentation of a physical or mental health condition from:

(a) a physician licensed pursuant to Title 37, chapter 3;

(b) an advanced practice registered nurse licensed pursuant to Title 37, chapter 8;

(c) a psychologist licensed pursuant to Title 37, chapter 17; or

(d) a physician assistant licensed pursuant to Title 37, chapter 20.

(4) A grant may be made under this section to an individual meeting the requirements of subsection (2) if the individual:

(a) has been a resident for at least 1 year; and

(b) provides income and resource information as required by the department by rule.

(5) The department shall exclude the value of the following items when calculating an applicant's resources:

(a) the applicant's primary vehicle; and

(b) the applicant's primary residence, up to a maximum of $100,000.

(6) The grant amount must be held by the department and used on behalf of the individual to pay the following expenses, in the order listed:

(a) any debt owed to the state;

(b) any debt owed to a hospital or critical access hospital, as those terms are defined in 50-5-101;

(c) the costs of premiums for a qualified health plan; and

(d) cost-sharing requirements for medical services received during the grant period, based on submission of receipts for medical services.

(7) The grant may be matched by funds from other sources in order to bring the individual's income to 100% of the federal poverty level for the purposes of purchasing a qualified health plan.

(8) (a) A grant provided under this section must be reported as income to the internal revenue service.

(b) The department shall file an internal revenue service form 1099 with the internal revenue service for each grant it makes and shall provide each individual receiving a grant with a copy of the form for the purpose of claiming the grant as income on federal tax forms.

(9) An individual who receives a grant under this section may not reapply for additional grants in future years.

(10) The department shall adopt rules to carry out the provisions of this section, including but not limited to rules establishing procedures for:

(a) accepting applications and determining eligibility;

(b) determining the resources that may be excluded from consideration under this section;

(c) determining whether an applicant owes a debt to the state, a hospital, or a critical access hospital; and

(d) making payments for health insurance premiums and medical costs.

NEW SECTION. **Section 8. Income-enhancement grant special revenue account -- statutory appropriation.** (1) There is an account in the state special revenue fund for the purposes of providing

income-enhancement grants pursuant to [section 7].

(2) Money from the proceeds of a conversion transaction that is approved pursuant to Title 50, chapter 4, part 7, must be deposited in the account.

(3) Any amount in the account that is not otherwise appropriated by law is statutorily appropriated, as provided in 17-7-502, from the account to the department of public health and human services to provide income-enhancement grants pursuant to [section 7].

NEW SECTION. **Section 9. Practice requirements for medical education program.** A Montana resident participating in the medical education program involving Washington, Wyoming, Alaska, Montana, and Idaho must be required to practice in Montana for 4 years upon graduation from medical school.

Section 10. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations: 2-17-105; 5-11-120; 5-11-407; 5-13-403; 7-4-2502; 10-1-108; 10-1-1202; 10-1-1303; 10-2-603; 10-3-203; 10-3-310; 10-3-312; 10-3-314; 10-4-301; 15-1-121; 15-1-218; 15-31-906; 15-35-108; 15-36-332; 15-37-117; 15-39-110; 15-65-121; 15-70-101; 15-70-369; 15-70-601; 16-11-509; 17-3-106; 17-3-112; 17-3-212; 17-3-222; 17-3-241; 17-6-101; 18-11-112; 19-3-319; 19-6-404; 19-6-410; 19-9-702; 19-13-604; 19-17-301; 19-18-512; 19-19-305; 19-19-506; 19-20-604; 19-20-607; 19-21-203; 20-8-107; 20-9-534; 20-9-622; 20-26-1503; 22-3-1004; 23-4-105; 23-5-306; 23-5-409; 23-5-612; 23-7-301; 23-7-402; 30-10-1004; 37-43-204; 37-51-501; 39-71-503; 41-5-2011; 42-2-105; 44-4-1101; 44-12-206; 44-13-102; 50-4-623; 53-1-109; [section 8]; 53-9-113; 53-24-108; 53-24-206; 60-11-115; 61-3-415; 69-3-870; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 76-13-416; 77-1-108; 77-2-362; 80-2-222; 80-4-416; 80-11-518; 81-1-112; 81-7-106; 81-10-103; 82-11-161; 85-20-1504; 85-20-1505; 87-1-230; 87-1-603;

87-1-621; 90-1-115; 90-1-205; 90-1-504; 90-3-1003; 90-6-331; and 90-9-306.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for the payments. (In subsection (3): pursuant to sec. 10, Ch. 360, L. 1999, the inclusion of 19-20-604 terminates when the amortization period for the teachers' retirement system's unfunded liability is 10 years or less; pursuant to sec. 10, Ch. 10, Sp. L. May 2000, secs. 3 and 6, Ch. 481, L. 2003, and sec. 2, Ch. 459, L. 2009, the inclusion of 15-35-108 terminates June 30, 2019; pursuant to sec. 17, Ch. 593, L. 2005, and sec. 1, Ch. 186, L. 2009, the inclusion of 15-31-906 terminates January 1, 2015; pursuant to sec. 73, Ch. 44, L. 2007, the inclusion of 19-6-410 terminates upon the death of the last recipient eligible under 19-6-709(2) for the supplemental benefit provided by 19-6-709; pursuant to sec. 8, Ch. 330, L. 2009, the inclusion of 87-1-621 terminates June 30, 2013; pursuant to sec. 14, Ch. 374, L. 2009, the inclusion of 53-9-113 terminates June 30, 2015; pursuant to sec. 8, Ch. 427, L. 2009, the inclusion of 87-1-230 terminates June 30, 2013; pursuant to sec. 5, Ch. 442, L. 2009, the inclusion of 90-6-331 terminates June 30, 2019; pursuant to sec. 47, Ch. 19, L. 2011, the inclusion of 87-1-621 terminates June 30, 2013; pursuant to sec. 16, Ch. 58, L. 2011, the inclusion of 30-10-1004 terminates June 30, 2017; pursuant to sec. 6, Ch. 61, L. 2011, the inclusion of 76-13-416 terminates June 30, 2019; and pursuant to sec. 13, Ch. 339, L. 2011, the inclusion of 81-1-112 and 81-7-106 terminates June 30, 2017.)"

Section 11. Section 50-4-716, MCA, is amended to read:

"50-4-716. Criteria for distribution of assets. (1) The public assets distributed ~~to a foundation or nonprofit organization~~ in accordance with 50-4-715 or 50-4-720 must be in the form of cash or a combination of cash and publicly traded securities or bonds or similar assets that are readily convertible to cash and for which a secondary market exists.

(2) The attorney general may determine that a distribution of assets of a nonprofit health entity is not required if the transaction is determined not to be a conversion transaction and is a transaction in the ordinary course of business and for fair market value.

(3) In determining fair market value, the attorney general may consider all relevant factors that may

include but are not limited to:

(a) the value of the nonprofit health entity or an affiliate or the assets of the nonprofit health entity or affiliate that are determined as if the nonprofit health entity or affiliate had voting stock outstanding and 100% of its stock was freely transferable and available for purchase without restriction;

(b) the value as a going concern;

(c) the market value;

(d) the investment or earnings value;

(e) the net asset value; and

(f) a control premium, if any."

Section 12. Section 50-4-720, MCA, is amended to read:

"50-4-720. Distribution of proceeds -- annual report. (1) Except as provided in ~~subsection (5)~~ subsections (2) and (6), the proceeds of a conversion transaction that are public assets must be distributed to an existing or new foundation or other nonprofit organization to be held in a trust that meets the following requirements:

(a) The foundation or nonprofit organization shall operate pursuant to 26 U.S.C. 501(c)(3) or 501(c)(4), and regardless of whether the foundation is classified as a private foundation under 26 U.S.C. 509, the foundation or nonprofit organization shall operate in accordance with the restrictions and limitations that apply to private foundations in 26 U.S.C. 4941 through 4945.

(b) The foundation or nonprofit organization must have a mission statement that is as close as possible to the mission of the converting nonprofit health entity.

(c) The foundation or nonprofit organization's assets may not be used to supplant government funds.

(d) The foundation or nonprofit organization may not be an agent or instrumentality of the government.

(e) The foundation or nonprofit organization and its directors, officers, and staff must be and shall remain independent of the parties to the conversion transaction and their affiliates. A person who is an officer, director, or staff member of a nonprofit health entity submitting a conversion plan at the time that the plan is submitted or at the time of the conversion transaction or within 5 years after the conversion may not be an officer, director, or staff member of the foundation. A director, officer, agent, or employee of the nonprofit health entity submitting the plan or the foundation receiving the charitable assets may not benefit directly or indirectly from the transaction. Public officials, elected or appointed, may not serve as an officer, director, or staff member of the foundation or

nonprofit organization.

(f) A foundation or nonprofit organization must have or shall establish formal mechanisms to avoid conflicts of interest and to prohibit grants benefiting:

(i) any party to the conversion transaction or members of the board of directors and management of a party to the conversion transaction; or

(ii) the foundation or nonprofit organization's board of trustees, directors, agents, or employees.

(g) Boards of trustees or directors of the foundation or nonprofit organization shall reflect the geographic, ethnic, gender, age, socioeconomic, and other factors that the board considers to represent the diversity of the nonprofit health entity applicant's service area. In addition, trustees or directors must have the following qualifications and qualities:

(i) interest in and concern for the foundation or nonprofit organization and its mission;

(ii) objectivity and impartiality;

(iii) willingness and ability to commit time and thought to the foundation or nonprofit organization's affairs; and

(iv) commitment to the foundation or nonprofit organization as a whole and not to a special interest.

(h) Boards of trustees or directors must include persons with special knowledge, expertise, and skills in investments and asset management, finance, and nonprofit administration.

(2) The first $10 million of proceeds of a conversion transaction that are public assets must be deposited in the income-enhancement grant special revenue account provided for in [section 8].

~~(2)~~(3) A foundation or nonprofit organization that receives a distribution of public assets shall submit an annual report to the commissioner and to the attorney general regarding the award of grants and other charitable activities of the entity related to its use of the public assets received.

~~(3)~~(4) The annual report submitted under subsection ~~(2)~~ (3) must be made available to the public at the principal office of the foundation or nonprofit organization.

~~(4)~~(5) The attorney general shall retain oversight and monitoring authority over the foundation or nonprofit organization that receives the proceeds of a proposed conversion transaction.

~~(5)~~(6) Notwithstanding any other provision of this section, the proceeds of a conversion transaction that are public assets of a nonprofit mutual benefit corporation in which all of the members are nonprofit public benefit corporations may be distributed to the member nonprofit public benefit corporations if the articles of incorporation of the nonprofit mutual benefit corporation provide for that distribution."

NEW SECTION. **Section 13. Appropriation.** (1) There is appropriated $2 million from the special revenue account provided for in [section 8] to the department of public health and human services for the biennium beginning July 1, 2013, to be used on education and outreach activities as provided in [section 6].

(2) (a) There is appropriated $400,000 from the general fund to the legislative services division for the citizens council on health care reform provided for in [section 4].

(b) Up to $250,000 of the appropriation may be used to hire consultants as provided in [section 4].

(3) There is appropriated from the general fund to the office of the commissioner of higher education $515,265 for the biennium beginning July 1, 2013, to expand the WWAMI medical education program.

NEW SECTION. **Section 14. Codification instruction.** (1) [Sections 1 through 8] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, part 1, apply to [sections 1 through 8].

(2) [Section 9] is intended to be codified as an integral part of Title 20, chapter 26, and the provisions of Title 20, chapter 26, apply to [section 9].

COORDINATION SECTION. **Section 15. Coordination instruction.** (1) If both House Bill No. 2 and [this act] are passed and approved and if House Bill No. 2 appropriates $515,265 to the office of commissioner of higher education to expand the number of eligible participants in the WWAMI program, then the appropriation in [section 13(3) of this act] is void.

(2) If both House Bill No. 2 and [this act] are passed and approved and if House Bill No. 2 appropriates less than $515,265 to the office of commissioner of higher education to expand the number of eligible participants in the WWAMI program, then the appropriation in House Bill No. 2 for the WWAMI expansion is void.

(3) If both House Bill No. 2 and [this act] are passed and approved and if House Bill No. 2 appropriates more than $515,265 to the office of commissioner of higher education to expand the number of eligible participants in the WWAMI program, then the appropriation in [section 13(3) of this act] is void.

COORDINATION SECTION. **Section 16. Coordination instruction.** If both House Bill No. 604 and [this act] are passed and approved, then House Bill No. 604 is void.

COORDINATION SECTION. **Section 17. Coordination instruction.** If both Senate Bill No. 391 and [this act] are passed and approved, then Senate Bill No. 391 is void.

NEW SECTION. **Section 18. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 19. Effective dates.** (1) [Sections 1 through 3, 5 through 10, and 13] are effective July 1, 2013.

(2) [Sections 4, 11, 12, and 14 through 21] are effective on passage and approval.

NEW SECTION. **Section 20. Applicability -- retroactive applicability.** (1) [Section 9] applies to students accepted into the WWAMI program beginning in the 2013-2014 academic year.

(2) [This act] applies retroactively, within the meaning of 1-2-109, to a conversion transaction of a nonprofit health entity that is approved by the commissioner of insurance and the attorney general on or after January 1, 2013.

NEW SECTION. **Section 21. Termination.** [Sections 1 through 8 and 10] terminate June 30, 2017.

- END -