1 HOUSE BILL NO. 658
2 INTRODUCED BY E. BUTTREY
3
4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH CARE LAWS; MAKING THE
5 MEDICAID EXPANSION PROGRAM PERMANENT BY REPEALING THE TERMINATION DATE OF THE
6 MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP ACT; ESTABLISHING COMMUNITY
7 ENGAGEMENT AND HEALTH RISK AND JOB READINESS ASSESSMENT REQUIREMENTS FOR HELP ACT
8 PARTICIPANTS; REVISING MEDICAID ELIGIBILITY VERIFICATION PROCEDURES; ESTABLISHING A HELP
9 ACT EMPLOYER GRANT PROGRAM; ESTABLISHING LIMITATIONS ON MEDICAL MALPRACTICE CLAIMS
10 WHEN A DOCUMENTED RATIONALE EXISTS FOR A MEDICAL TREATMENT; ENACTING A FEE ON
11 HEALTH SERVICE CORPORATIONS; APPLYING THE INSURANCE PREMIUM TAX TO THE MONTANA
12 STATE FUND; ESTABLISHING A FEE ON HOSPITAL OUTPATIENT REVENUE; REVISING TAXPAYER
13 INTEGRITY FEES; CREATING A SPECIAL REVENUE ACCOUNT; EXTENDING RULEMAKING AUTHORITY;
14 PROVIDING APPROPRIATIONS; REMOVING STATUTORY APPROPRIATIONS; AMENDING SECTIONS
15 15-30-2660, 15-66-101, 15-66-102, 15-66-103, 15-66-201, 15-66-202, 15-66-203, 15-66-204, 15-66-205,
16 17-7-502, 33-1-115, 33-2-705, 33-2-708, 33-30-102, 39-12-101, 39-12-103, 39-71-2375, 53-4-1110, 53-4-1115,
17 53-6-131, 53-6-133, 53-6-149, 53-6-160, 53-6-1302, 53-6-1303, 53-6-1304, 53-6-1305, 53-6-1306, 53-6-1307,
18 53-6-1311, AND 53-6-1317, MCA; REPEALING SECTION 53-6-1316, MCA; AMENDING AND REPEALING
19 SECTION 28, CHAPTER 368, LAWS OF 2015; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY
20 DATE."
21
22 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
23
24 NEW SECTION. **Section 1. Community engagement requirements -- countable activities --**
25 **exemptions -- self-attestation.** (1) Except as provided in subsections (3) through (5), an individual receiving
26 coverage under this part shall participate in 80 hours of community engagement activities each month if the
27 individual is at least 19 years of age but no more than 59 years of age.
28 (2) Time spent in one or more of the following activities may be counted toward the monthly requirement
29 for community engagement:
30 (a) employment as evidenced through reportable wages;

1 (b) activities required to obtain unemployment insurance pursuant to Title 39, chapter 51;
2 (c) a workforce training program approved by the state;
3 (d) part-time enrollment for credit in a postsecondary institution, with one credit unit equaling 3 hours a
4 week of time counted toward the community engagement requirements;
5 (e) active treatment in a behavioral health or substance use disorder treatment program approved by
6 the department;
7 (f) a community corrections program providing the services listed in 53-30-303(2)(b); or
8 (g) a community service or volunteer opportunity that is approved by the department.
9 (3) A program participant is exempt from the requirements of this section if the participant attests that
10 the participant is:
11 (a) medically frail as defined in 42 CFR 440.315;
12 (b) receiving temporary or permanent disability benefits from a government or private source;
13 (c) a full-time caregiver for a dependent child under the age of compulsory school attendance;
14 (d) a full-time caregiver for a disabled child or adult who is receiving temporary or permanent disability
15 benefits from a government or private source;
16 (e) a full-time student enrolled in:
17 (i) a secondary school; or
18 (ii) a postsecondary institution that does not offer a health care plan to students;
19 (f) incarcerated in a state prison as defined in 53-30-101 or held in a county jail for a period of 30 days
20 or more;
21 (g) (i) pregnant and determined by the individual's health care provider to be unable to fulfill the
22 community engagement requirements because of risks or complications associated with the pregnancy; or
23 (ii) less than 60 days postpartum;
24 (h) a member of a population for whom the federal government generally pays the cost of health care
25 services covered under this part; or
26 (i) a member of an entity subject to the fee provided for in 15-30-2660(3).
27 (4) A program participant is exempt from the requirements of this section if the department is able to
28 verify that the individual is employed and that the individual's wages are equal to or greater than 100% of the
29 federal poverty level for the household size reported for the purposes of qualifying for medicaid under this part.
30 The department shall verify the participant's wages on a quarterly basis.

1 (5) A program participant is exempt from the requirements of this section in any month in which the
2 participant attests that the participant:
3 (a) is hospitalized or caring for an immediate family member who has been hospitalized; or
4 (b) has a documented serious illness or incapacity or is caring for an immediate family member with a
5 documented serious illness or incapacity.
6 (6) A program participant who accepts an opportunity to participate in a community service or volunteer
7 opportunity to satisfy the requirements of this section:
8 (a) consents to any risks that may be inherent in the opportunity; and
9 (b) is a volunteer as defined in 39-71-118(2)(b) and not eligible for workers' compensation under Title
10 39, chapter 71.
11 (7) (a) The department may certify, through use of available data systems, that a program participant:
12 (i) meets the community engagement requirements of this section; or
13 (ii) is exempt from meeting the community engagement requirements.
14 (b) The department shall notify program participants for whom it can verify community engagement
15 requirements or exemptions that the participants do not have to comply with the attestation requirements of
16 [section 1] or the reporting requirements of [section 2], as applicable.
17
18 NEW SECTION. **Section 2. Community engagement -- self-reporting of compliance --**
19 **disenrollment.** (1) (a) Unless a program participant is exempt from the community engagement requirements
20 of [section 1] or has been certified by the department as meeting the requirements, the participant shall report
21 on a quarterly basis that the participant has met the requirements. The department shall adopt rules establishing
22 reporting requirements. The rules must:
23 (i) specify the manner in which hours are calculated to determine compliance with the community
24 engagement requirements; and
25 (ii) take into account a participant's customary hours of employment if the participant is employed in an
26 occupation for which hours vary based on demand for the services provided.
27 (b) The participant may report on community engagement activities verbally, in writing, or electronically.
28 The department shall develop a means for providing the report electronically.
29 (2) The department shall notify a program participant who is not in compliance with the community
30 engagement requirements that:

1 (a) the participant has 90 days to come into compliance; and
2 (b) failure to comply within the 90-day period will be considered a voluntary disenrollment from the
3 program unless the participant attests that the participant is exempt from the community engagement
4 requirements as allowed under [section 1].
5 (3) A participant who is disenrolled from the program for noncompliance may apply to reenroll 180 days
6 after the date of disenrollment.
7 (4) An individual newly enrolled in coverage under this part has 90 days from the time of enrollment to
8 comply with the community engagement requirements.
9 (5) If a program participant has attested to an exemption from the requirements as allowed under [section
10 1(5)], the department shall verify on a quarterly basis that the participant continues to meet the conditions for an
11 exemption.
12
13 NEW SECTION. **Section 3. Health risk and employment readiness assessments -- exceptions --**
14 **disenrollment for failure to complete.** (1) Within 6 months of enrolling in the program, a program participant
15 shall complete:
16 (a) a form assessing health risks; and
17 (b) a form assessing employment readiness.
18 (2) The department shall:
19 (a) develop the assessment forms, consulting with the department of labor and industry to develop the
20 employment readiness assessment form;
21 (b) allow a program participant to complete the assessments verbally by phone, in writing, or through
22 an electronic means;
23 (c) provide the results of both assessments to the participant; and
24 (d) provide the results of the employment readiness assessment to the department of labor and industry
25 to assist with carrying out the workforce development activities provided for in Title 39, chapter 12.
26 (3) Except as provided in subsection (4), a participant shall complete a health risk assessment and an
27 employment readiness assessment each year.
28 (4) (a) A participant is exempt from completing a health risk assessment in any year in which the
29 participant has a preventive care visit as defined by the department by rule.
30 (b) A participant is exempt from completing an employment readiness assessment other than the initial

1 assessment in any year in which the participant is exempt, under [section 1(3)], from meeting the community
2 engagement requirements of this part.
3 (5) The department shall disenroll a program participant who fails to complete an initial assessment
4 within 6 months of receiving benefits under this part or who fails to complete an additional assessment as
5 required during any subsequent year of continuous coverage under this part. The individual may apply to reenroll
6 6 months after the date of disenrollment.
7
8 NEW SECTION. **Section 4. Department auditing of self- attestations and self-reporting -- agency**
9 **sharing of information.** (1) The department shall audit on a quarterly basis the reports and attestations of
10 program participants relating to their participation in or exemption from community engagement requirements,
11 unless the department has verified that the participant is earning 100% or more of the federal poverty level for
12 the household size reported for the purposes of qualifying for medicaid under this part.
13 (2) The department shall audit a statistically valid sample of program participants to determine, with a
14 confidence interval of 95% and a level of precision of 3%, whether the error rate on self-reporting and
15 self-attestation is 10% or less.
16 (3) If the audit shows that more than 10% of program participants may have provided incorrect
17 information, the department shall double the number of audits conducted each quarter until the audits find that
18 fewer than 10% of program participants are incorrectly reporting their community engagement activities or
19 exemptions.
20 (4) A participant found to have intentionally filed an incorrect report of community engagement activities
21 or to have intentionally claimed an exemption to which the participant was not entitled must be disenrolled from
22 the program. The individual may apply to reenroll 12 months after the date of disenrollment.
23 (5) (a) State agencies shall share information as allowed under this section if requested by the
24 department for an audit of a program participant's reporting of community engagement activities or attestation
25 of an exemption, only to the extent necessary to verify the accuracy of the reporting or attestation.
26 (b) The department of labor and industry shall provide information related to quarterly wage reports,
27 unemployment-related activities, participation in workforce training programs operated or approved by the
28 department of labor and industry, or determinations of a permanent, partial, or temporary disability for which a
29 person is receiving workers' compensation benefits.
30 (c) The department of corrections shall provide information about participation in a community

1 corrections program or the incarceration status or length of incarceration for a program participant.
2 (6) The Montana university system may share information about a program participant's educational
3 status and credit hours if requested by the department for the purposes of an audit under this section.
4
5 NEW SECTION. **Section 5. Disenrollment for failure to report change in circumstances.** (1) (a) A
6 program participant shall report to the department a permanent increase in income that would affect the
7 participant's eligibility for the program. The change must be reported within 10 days of the change in income.
8 (b) A short-term increase in income that is caused by overtime pay or other nonregular payments and
9 that will not be sustained over time does not qualify as a permanent increase in income for the purposes of this
10 section.
11 (2) Disenrollment may occur only after the state conducts an administrative review and determines the
12 participant is ineligible for medicaid coverage under any eligibility category.
13 (3) Except as provided in subsection (4), a program participant who is disenrolled for failure to report an
14 increase in income is prohibited from applying for reenrollment under this part for 6 months.
15 (4) A disenrolled individual is eligible for early reenrollment at any time before the end of the 6-month
16 noneligibility period if required by:
17 (a) federal law or regulation; or
18 (b) the special terms and conditions of any waiver approved by the centers for medicare and medicaid
19 services for carrying out the provisions of this part.
20
21 NEW SECTION. **Section 6. Montana HELP Act special revenue account.** (1) There is a Montana
22 HELP Act account in the state special revenue fund to the credit of the department.
23 (2) Money from the following sources must be deposited in the account:
24 (a) the taxpayer integrity fees provided for in 15-30-2660;
25 (b) the outpatient hospital utilization fee provided for in 15-66-102(3)(b);
26 (c) the premium tax paid under 33-2-705 by the state fund provided for in 39-71-2313;
27 (d) the health service corporation fee provided for in [section 8]; and
28 (e) premiums paid by members pursuant to 53-6-1307.
29 (3) Money in the account must be used to pay for:
30 (a) the state share of costs, including benefits and administrative costs, of providing health care services

1 under this part; and
2 (b) grants made under the HELP Act employer grant program provided for in [section 9].
3 (4) Money from the account must be used for the benefits and administrative costs of providing health
4 care services under this part before any general fund is expended on the costs.
5
6 NEW SECTION. **Section 7. Health care provider negligence claims prohibited when using medical**
7 **judgment.** (1) A health care provider, including a provider practicing telemedicine as defined in 37-3-102, may
8 not be found negligent in a medical malpractice claim if in exercising the health care provider's medical judgment
9 the provider:
10 (a) selects a reasonably prudent course of treatment, after discussion with the patient or the patient's
11 guardian or representative, if applicable; and
12 (b) includes the documented rationale for the decision in the patient's medical record.
13 (2) For the purposes of this section, a selected course of treatment may be reasonably prudent even if
14 it ultimately was not successful or the patient did not experience the desired outcome or result.
15 (3) This section may not be construed to impose any additional duties on a health care provider.
16 (4) As used in this section, the following definitions apply:
17 (a) "Documented rationale" means a brief statement written by a health care provider at the time of
18 treatment that includes the provider's medical rationale for prescribing or not prescribing, recommending or not
19 recommending, or ordering or not ordering a given test, procedure, treatment, consultation, or other therapeutic
20 intervention.
21 (b) "Health care provider" means:
22 (i) a physician, dentist, podiatrist, optometrist, advanced practice registered nurse, or physician assistant
23 licensed under Title 37; or
24 (ii) a health care facility licensed under Title 50, chapter 5.
25
26 NEW SECTION. **Section 8. Health service corporation fee.** (1) An authorized health service
27 corporation as defined in 33-30-101 shall file with the commissioner, on or before March 1 of each year, a report
28 in a format prescribed by the commissioner showing the total direct premium income from all sources after
29 deducting from the income applicable cancellations, returned premiums, or the amount of reduction in or refund
30 of premiums.

1 (2) At the time the report is filed, and subject to 33-2-709, the health service corporation shall pay a fee
2 to the commissioner on net premium income computed at the rate of 1%.
3 (3) If a health service corporation fails to pay the fee required under this section, the commissioner may:
4 (a) suspend or revoke the certificate of authority for the health service corporation; and
5 (b) impose a fine of $100 plus interest on the delinquent amount at an annual interest rate of 12%.
6 (4) The commissioner may provide by rule a quarterly schedule for the payment of the fee.
7 (5) The commissioner shall deposit money collected from the fee into the Montana HELP Act special
8 revenue account provided for in [section 6].
9 (6) The fee required under this section applies to a formerly authorized health service corporation with
10 respect to premiums received while an authorized health service corporation in this state.
11
12 NEW SECTION. **Section 9. Montana HELP Act employer grant program.** (1) There is a Montana
13 HELP Act employer grant program to encourage employers to hire or train program participants in skills that will
14 allow them to:
15 (a) obtain new or improved employment;
16 (b) obtain employment with health care benefits;
17 (c) earn a wage that allows them to purchase their own health insurance coverage; or
18 (d) improve their long-term financial security.
19 (2) The department shall establish criteria for awarding grants. The criteria must take into consideration,
20 at a minimum, the number of program participants affected and the likelihood that the proposed grant activity will
21 improve:
22 (a) the chances that program participants will succeed in obtaining employment meeting the goals of
23 subsection (1); or
24 (b) the financial security of program participants through efforts that include:
25 (i) financial and credit counseling; and
26 (ii) educational opportunities related to managing finances and setting and reaching financial goals.
27 (3) The department shall adopt rules establishing grant application, evaluation, and award criteria and
28 processes.
29
30 **Section 10.** Section 15-30-2660, MCA, is amended to read:

1 **"15-30-2660. ~~(Temporary)~~ Taxpayer integrity ~~fee~~ fees.** (1) (a) The department shall assess a fee as
2 provided in subsection (2) for a taxpayer who~~:~~
3 ~~(a)~~ is a participant in the Montana Health and Economic Livelihood Partnership Act provided for in Title
4 53, chapter 6, part 13, and Title 39, chapter 12~~;~~, and owns:
5 ~~(b) has assets that exceed:~~
6 (i) ~~a primary residence and attached property~~ real property or improvements to real property, or both,
7 valued above the limit established for homesteads under 70-32-104, if the real property is not agricultural land;
8 (ii) more than one light vehicle, and the additional vehicles have a combined depreciated value of the
9 manufacturer's suggested retail price of $20,000; ~~and~~ or
10 ~~(iii) a total of $50,000 in cash and cash equivalent~~
11 (iii) agricultural land with a taxable value in excess of $1,500 a year.
12 (b) For the purposes of subsection (1)(a)(ii), the depreciated value of the manufacturer's suggested retail
13 price must be computed as provided in 61-3-503(2).
14 (2) The fee is $100 a month plus an amount equal to an additional $4 a month for:
15 (a) each $1,000 in ~~assets above the amounts established in subsection (1)(b)~~ value above the limit
16 established for homesteads under 70-32-104, if the individual has real property or improvements to real property,
17 or both, that exceed the value for homesteads;
18 (b) each $1,000 above the combined depreciated value allowed for vehicles in subsection (1)(a)(ii), if
19 the taxpayer owns more than one vehicle; and
20 (c) each $100 of taxable value of any agricultural land the taxpayer owns in excess of the taxable value
21 threshold provided in subsection (1)(a)(iii).
22 (3) (a) The department shall assess a fee for an entity organized under 26 U.S.C. 501(d) and subject to
23 taxes as provided in Title 15, chapter 31, if the entity has members who are receiving medicaid coverage under
24 Title 53, chapter 6, part 13.
25 (b) The fee is equal to the state's share of the average annual cost per program participant, as defined
26 in 53-6-1303, multiplied by the number of individuals in the 26 U.S.C. 501(d) organization who are receiving
27 medicaid coverage because they are eligible under 53-6-1304, less the total annual amount the entity's members
28 have paid in premiums.
29 (4) (a) For the purposes of calculating the fee required under subsection (3), the department of public
30 health and human services shall provide the department of revenue by February 1 of each year with:

1 (i) the percentage of medicaid claims costs of program participants for which the state was responsible
2 in the previous calendar year; and
3 (ii) the average annual cost of medical claims for program participants in the previous calendar year.
4 (b) The department of public health and human services shall post the average annual cost for a
5 program participant on the department's website by February 15 of each year.
6 (5) An organization shall pay the fee provided for in subsection (3) as follows:
7 (a) on or before the last day of each month, the organization shall pay an estimated fee equal to
8 one-twelfth of the most recently published annual cost per program participant; and
9 (b) on or before April 15 of each year, the organization shall report and pay any additional amount owed
10 for the prior year or request a refund of any overpayment made in the prior year.
11 ~~(3)~~(6) (a) The department of public health and human services shall ~~coordinate with~~ provide the
12 department of ~~public health and human services to obtain the information necessary to administer~~ revenue with
13 the names of program participants and other necessary information to assist the department of revenue in
14 administering and enforcing this section.
15 (b) The department of justice shall provide the department of revenue with vehicle registration
16 information for the administration of this section.
17 ~~(4)~~(7) Fees collected pursuant to this section must be deposited in the ~~general fund~~ Montana HELP Act
18 special revenue account provided for in [section 6].
19 ~~(5)~~(8) ~~The~~ A fee remains until paid and may be collected through assessments against future income
20 tax returns or through a civil action initiated by the state.
21 ~~(6)~~(9) For the purposes of this section, the following definitions apply:
22 ~~(a) (i) "Cash equivalent" means cash, including any money issued by the United States or by the~~
23 ~~sovereign government of another country, and, if reasonably convertible into cash with 1 year:~~
24 ~~(A) personal property, including but not limited to vehicles, precious metal as defined in 30-10-103,~~
25 ~~jewelry, artwork, and gemstones; and~~
26 ~~(B) personal property, including but not limited to certificates of deposit, certificates of stock, government~~
27 ~~or corporate bonds or notes, promissory notes, licenses, copyrights, patents, trademarks, contracts, software,~~
28 ~~and franchises.~~
29 ~~(ii) Real estate and improvements to real estate are not cash equivalents.~~
30 (a) (i) "Agricultural land" means agricultural land as described in 15-7-202 that is taxed as class three

property at the rate provided in 15-6-133.

(ii) The term does not include parcels of land that are considered nonqualified agricultural land as provided in 15-6-133(1)(c) or improvements to real property.

(b) "Light vehicle" has the meaning provided in 61-1-101.

(c) "Manufacturer's suggested retail price" has the meaning provided in 61-3-503(3). ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 11. Section 15-66-101, MCA, is amended to read:

"15-66-101. (Temporary) Definitions. For purposes of this chapter, the following definitions apply:

(1) (a) "Hospital" ~~means a facility licensed as a hospital pursuant to Title 50, chapter 5,~~ has the meaning provided in 50-5-101 and includes a critical access hospital as defined in 50-5-101.

(b) The term does not include the Montana state hospital or a government hospital not owned by the state.

(2) (a) "Hospital outpatient revenue" means the gross revenue from a hospital's charges for services provided on an outpatient basis.

(b) The term does not include charges for professional services provided as part of the outpatient treatment.

~~(2)~~(3) (a) "Inpatient bed day" means a day of inpatient care provided to a patient in a hospital. A day begins at midnight and ends 24 hours later. A part of a day, including the day of admission, counts as a full day. The day of discharge or death is not counted as a day. If admission and discharge or death occur on the same day, the day is considered a day of admission and is counted as one inpatient bed day. Inpatient bed days include all inpatient hospital benefit days as defined for medicare reporting purposes in section 20.1 of chapter 3 of the centers for medicare and medicaid services publication 100-02, the Medicare Benefit Policy Manual. Inpatient bed days also include all nursery days during which a newborn infant receives care in a nursery.

(b) The term does not include observation days or days of care in a swing bed, as defined in 50-5-101.

~~(3)~~(4) "Patient" means an individual obtaining skilled medical and nursing services in a hospital. The term includes newborn infants.

~~(4)~~(5) "Report" means the report of inpatient bed days and hospital outpatient revenue required in 15-66-201.

~~(5)~~(6) "Utilization fee" or "fee" means the ~~fee~~ fees required to be paid ~~for each inpatient bed day,~~ as

provided in 15-66-102. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 12. Section 15-66-102, MCA, is amended to read:

"15-66-102. (Temporary) Utilization ~~fee for~~ fees -- inpatient bed days -- hospital outpatient revenue. (1) Each hospital in the state shall pay to the department a utilization fee in the amount of ~~$50~~ $70 for each inpatient bed day.

(2) Each hospital shall pay to the department a utilization fee in the amount of 0.825% of hospital outpatient revenue.

~~(2)~~(3) (a) ~~All~~ Except as provided in subsection (3)(b), all proceeds from the collection of utilization fees, including penalties and interest, must, in accordance with the provisions of 17-2-124, be deposited to the credit of the department of public health and human services in ~~a~~ the state special revenue account ~~as~~ provided for in 53-6-149.

(b) The department shall deposit 50% of the amount paid in accordance with subsection (2) in the Montana HELP Act special revenue account provided for in [section 6]. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 13. Section 15-66-103, MCA, is amended to read:

"15-66-103. (Temporary) Relation to other taxes and fees. The utilization ~~fee~~ fees imposed under 15-66-102 ~~is~~ are in addition to any other taxes and fees required to be paid by hospitals. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 14. Section 15-66-201, MCA, is amended to read:

"15-66-201. (Temporary) Reporting and collection of ~~fee~~ fees. (1) On or before ~~January~~ March 31 of each year, a hospital shall file with the department an annual report of the number of inpatient bed days and of hospital outpatient revenue during the preceding year beginning January 1 and ending December 31. The report must be in the form prescribed by the department. The report must be accompanied by a payment in an amount equal to the ~~fee~~ fees required to be paid under 15-66-102.

(2) On or before January 31 of each year, the department of public health and human services shall provide the department with a list of hospitals licensed and operating in the state and subject to the provisions

of 15-66-102 during the preceding year beginning January 1 and ending December 31. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 15. Section 15-66-202, MCA, is amended to read:

"15-66-202. (Temporary) Audit -- records. (1) The department may audit the records and other documents of any hospital to ensure that the proper utilization ~~fee has~~ fees have been collected.

(2) The department may require the hospital to provide records and other documentation, including books, ledgers, and registers, necessary for the department to verify the proper amount of the utilization fee paid.

(3) A hospital shall maintain and make available for inspection by the department sufficient records and other documentation to demonstrate the number of inpatient bed days in the facility and the hospital outpatient revenue subject to the utilization ~~fee~~ fees. The facility shall maintain these records for a period of at least 5 years from the date the report is due. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 16. Section 15-66-203, MCA, is amended to read:

"15-66-203. (Temporary) Periods of limitation. (1) Except as otherwise provided in this section, a deficiency may not be assessed or collected with respect to the year for which a report is filed unless the notice of additional fees proposed to be assessed is mailed within 5 years from the date the report was filed. For the purposes of this section, a report filed before the last day prescribed for filing is considered filed on the last day. If, before the expiration of the period prescribed for assessment of the ~~fee~~ fees, the hospital consents in writing to an assessment after the 5-year period, the ~~fee~~ fees may be assessed at any time prior to the expiration of the period agreed upon.

(2) A refund or credit may not be paid or allowed with respect to the year for which a report is filed after 5 years from the last day prescribed for filing the report or after 1 year from the date of the overpayment, whichever period expires later, unless before the expiration of the period, the hospital files a claim or the department has determined the existence of the overpayment and has approved the refund or credit. If the hospital has agreed in writing under the provisions of subsection (1) to extend the time within which the department may propose an additional assessment, the period within which a claim for refund or credit is filed or a credit or refund is allowed if a claim is not filed is automatically extended. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 17. Section 15-66-204, MCA, is amended to read:

"15-66-204. (Temporary) Penalty and interest for delinquent fees -- waiver. If the ~~fee~~ fees for any hospital ~~is~~ are not paid on or before the due date of the report as provided in 15-66-201, penalty and interest, as provided in 15-1-216, must be added to the ~~fee~~ fees. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 18. Section 15-66-205, MCA, is amended to read:

"15-66-205. (Temporary) ~~Estimated fee on failure to file~~ Department authority to request information. For the purpose of ascertaining the correctness of any report or for the purpose of making an estimate of inpatient bed day use or hospital outpatient revenue of any hospital for which information has been obtained, the department may:

(1) examine or cause to have examined by any designated agent or representative any books, papers, records, or memoranda bearing ~~upon~~ on the matters required to be included in the report;

(2) require the attendance of any officer or employee of the facility rendering the report or the attendance of any other person in the premises having relevant knowledge; and

(3) take testimony and require production of any other material for its information. (Void on occurrence of contingency--sec. 18, Ch. 390, L. 2003--see chapter compiler's comment.)"

Section 19. 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; 10-2-807; 10-3-203; 10-3-310;

10-3-312; 10-3-314; 10-3-1304; 10-4-304; 15-1-121; 15-1-218; 15-35-108; 15-36-332; 15-37-117; 15-39-110; 15-65-121; 15-70-101; 15-70-130; 15-70-433; 16-11-119; 16-11-509; 17-3-106; 17-3-112; 17-3-212; 17-3-222; 17-3-241; 17-6-101; 17-7-215; 18-11-112; 19-3-319; 19-3-320; 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; 20-9-905; 20-26-617; 20-26-1503; 22-1-327; 22-3-116; 22-3-117; 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; 37-50-209; 37-51-501; 37-54-113; 39-71-503; 41-5-2011; 42-2-105; 44-4-1101; 44-12-213; 44-13-102; 50-1-115; 53-1-109; 53-6-148; ~~53-6-1304~~; 53-9-113; 53-24-108; 53-24-206; 60-11-115; 61-3-321; 61-3-415; 69-3-870; 69-4-527; 75-1-1101; 75-5-1108; 75-6-214; 75-11-313; 75-26-308; 76-13-150; 76-13-416; 76-17-103; 76-22-109; 77-1-108; 77-2-362; 80-2-222; 80-4-416; 80-11-518; 80-11-1006; 81-1-112; 81-1-113; 81-7-106; 81-10-103; 82-11-161; 85-20-1504; 85-20-1505; [85-25-102]; 87-1-603; 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 contingently 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. 73, Ch. 44, L. 2007, the inclusion of 19-6-410 terminates contingently 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. 6, Ch. 61, L. 2011, the inclusion of 76-13-416 terminates June 30, 2019; pursuant to sec. 11(2), Ch. 17, L. 2013, the inclusion of 17-3-112 terminates on occurrence of contingency; pursuant to sec. 27, Ch. 285, L. 2015, and sec. 1, Ch. 292, L. 2015, the inclusion of 53-9-113 terminates June 30, 2021; pursuant to sec. 6, Ch. 291, L. 2015, the inclusion of 50-1-115 terminates June 30, 2021; ~~pursuant to sec. 28, Ch. 368, L. 2015, the inclusion of 53-6-1304 terminates June 30, 2019;~~ pursuant to sec. 5, Ch. 383, L. 2015, the inclusion of 85-25-102 is effective on occurrence of contingency; pursuant to sec. 5, Ch. 422, L. 2015, the inclusion of 17-7-215 terminates June 30, 2021; pursuant to sec. 6, Ch. 423, L. 2015, the inclusion of 22-3-116 and 22-3-117 terminates June 30, 2025; pursuant to sec. 10, Ch. 427, L. 2015, the inclusion of 37-50-209 terminates September 30, 2019; pursuant to sec. 33, Ch. 457,

1 L. 2015, the inclusion of 20-9-905 terminates December 31, 2023; pursuant to sec. 12, Ch. 55, L. 2017, the
2 inclusion of 37-54-113 terminates June 30, 2023; pursuant to sec. 4, Ch. 122, L. 2017, the inclusion of 10-3-1304
3 terminates September 30, 2025; pursuant to sec. 55, Ch. 151, L. 2017, the inclusion of 30-10-1004 terminates
4 June 30, 2021; pursuant to sec. 1, Ch. 213, L. 2017, the inclusion of 90-6-331 terminates June 30, 2027; pursuant
5 to secs. 5, 8, Ch. 284, L. 2017, the inclusion of 81-1-112, 81-1-113, and 81-7-106 terminates June 30, 2023;
6 pursuant to sec. 1, Ch. 340, L. 2017, the inclusion of 22-1-327 terminates July 1, 2023, and pursuant to sec. 2,
7 Ch. 340, L. 2017, and sec. 32, Ch. 429, L. 2017, is void for fiscal years 2018 and 2019; and pursuant to sec. 10,
8 Ch. 374, L. 2017, the inclusion of 76-17-103 terminates June 30, 2027.)"
9
10 **Section 20.** Section 33-1-115, MCA, is amended to read:
11 **"33-1-115. Operation of state fund as authorized insurer -- issuance of certificate of authority --**
12 **exceptions -- use of calendar year -- risk-based capital -- reporting requirements.** (1) The state fund
13 provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the
14 provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and
15 the provisions of Title 39, chapter 71, part 23.
16 (2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers'
17 compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section
18 the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously
19 renewed by the commissioner.
20 (b) The state fund shall pay the tax on net premiums under 33-2-705 and the annual fee under 33-2-708,
21 provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available
22 documentation and information that is provided by other insurers when applying for a certificate of authority under
23 33-2-115.
24 (c) The state fund is subject to the reporting requirements under 33-2-705 ~~but is not subject to the tax~~
25 ~~on net premiums~~.
26 (3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers
27 pursuant to 39-71-2313, is not subject to:
28 (i) formation requirements of an insurer under Title 33, chapter 3;
29 (ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or
30 any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

1 (iii) liquidation or dissolution under Title 33;
2 (iv) participation in the guaranty association provided for in Title 33, chapter 10;
3 (v) 33-12-104; or
4 (vi) any assessment of punitive or exemplary damages.
5 (b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).
6 (4) The state fund shall complete financial reporting and accounting on a calendar year basis.
7 (5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in
8 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the
9 legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and
10 to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory
11 implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the
12 commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's
13 corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders
14 issued by the commissioner.
15 (b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may
16 initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to
17 comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may
18 institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for
19 rehabilitation based on the grounds provided in 33-2-1321(1) or (2).
20 (6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary
21 staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner
22 qualified by education, training, experience, and high professional competence to examine the state fund
23 pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the
24 commissioner.
25 (7) For the purposes of this section, the term "guaranteed market" has the definition provided in
26 39-71-2312."
27
28 **Section 21.** Section 33-2-705, MCA, is amended to read:
29 **"33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and each
30 formerly authorized insurer with respect to premiums received while an authorized insurer in this state shall file

1 with the commissioner, on or before March 1 each year, a report in a form prescribed by the commissioner
2 showing total direct premium income, including policy, membership, and other fees, premiums paid by application
3 of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new
4 or additional or extended or renewed insurance, charges for payment of premium in installments, and all other
5 consideration for insurance from all kinds and classes of insurance, whether designated as a premium or
6 otherwise, received by a life insurer or written by an insurer other than a life insurer during the preceding calendar
7 year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana,
8 with proper proportionate allocation of premium as to property, subjects, or risks in Montana insured under
9 policies or contracts covering property, subjects, or risks located or resident in more than one state, after
10 deducting from the total direct premium income applicable cancellations, returned premiums, the unabsorbed
11 portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life
12 policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings,
13 savings coupons, and other similar returns paid or credited to policyholders with respect to the policies. As to title
14 insurance, "premium" includes the total charge for the insurance. A deduction may not be made of the cash
15 surrender values of policies. Considerations received on annuity contracts may not be included in total direct
16 premium income and are not subject to tax.
17 (2) (a) Except as provided in subsections (2)(b) and (2)(c), coincident with the filing of the tax report
18 referred to in subsection (1) and subject to 33-2-709, each insurer shall pay to the commissioner a tax on the net
19 premiums computed at the rate of 2.75%.
20 (b) All casualty insurers issuing policies of legal professional liability insurance pursuant to 33-1-206 shall
21 pay to the commissioner a tax on the net premiums derived from legal professional liability insurance computed
22 at a rate of 0.75%.
23 (c) A dormant captive insurer that has a valid certificate of dormancy shall pay to the commissioner an
24 annual dormancy tax of $1,000 as provided in 33-28-401.
25 (3) That portion of the tax paid under this section by an insurer on account of premiums received for fire
26 insurance must be separately specified in the report required by the commissioner for apportionment as provided
27 by law. When insurance against fire is included with insurance of property against other perils at an undivided
28 premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the
29 coverage as must be stated in the report and as may be approved or accepted by the commissioner.
30 (4) With respect to authorized insurers, the premium tax provided by this section or the annual dormancy

tax under 33-28-401 must be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer that fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose on an insurer who fails to pay the tax required under this section a fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%.

(7) The commissioner shall:

(a) separately account for taxes paid under this section by the state fund provided for in 39-71-2313; and

(b) deposit the money as provided in 33-2-708.

~~(7)~~(8) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which tax liability is accrued."

Section 22. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) (a) Except as provided in subsection (5), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

1 (A) application for original license, including issuance of license, if issued, $50;
2 (B) biennial renewal of license, $100;
3 (C) lapsed license reinstatement fee, $200;
4 (v) insurance consultant's license:
5 (A) application for original license, including issuance of license, if issued, $50;
6 (B) biennial renewal of license, $100;
7 (C) lapsed license reinstatement fee, $200;
8 (vi) viatical settlement broker's license:
9 (A) application for original license, including issuance of license, if issued, $50;
10 (B) biennial renewal of license, $100;
11 (C) lapsed license reinstatement fee, $200;
12 (vii) resident and nonresident rental car entity producer's license:
13 (A) application for original license, including issuance of license, if issued, $100;
14 (B) quarterly filing fee, $25;
15 (viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in
16 accordance with 33-20-1303(2)(b), $50;
17 (ix) navigator certification:
18 (A) application for original certification, including issuance of certificate if issued, $100;
19 (B) biennial renewal of certification, $50;
20 (C) lapsed certification reinstatement fee, $100;
21 (x) 50 cents for each page for copies of documents on file in the commissioner's office.
22 (c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer,
23 a surplus lines insurance producer, an insurance adjuster, an insurance public adjuster, or an insurance
24 consultant is required to pay the fee for the biennial renewal of a license.
25 (2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as
26 required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization
27 submitting courses or programs for review in any biennium.
28 (b) Insurers and associations composed of members of the insurance industry are exempt from the
29 charge in subsection (2)(a).
30 (3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state

1 treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to
2 33-2-311, 33-2-705, 33-28-201, and 50-3-109.
3 (b) The commissioner shall deposit:
4 (i) money from the premium tax paid by the state fund pursuant to 33-2-705 in the Montana HELP ACT
5 special revenue account provided for in [section 6]; and
6 (ii) 33% of the remaining money collected under 33-2-705 in the special revenue account provided for
7 in 53-4-1115.
8 (c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title
9 33 must be deposited in the state special revenue fund to the credit of the state auditor's office [and are subject
10 to legislative fund transfer].
11 (4) All fees are considered fully earned when received. In the event of overpayment, only those amounts
12 in excess of $10 will be refunded.
13 (5) The commissioner shall collect a licensing fee of $500 for casualty insurance companies issuing
14 policies of legal professional liability insurance pursuant to 33-1-206. (Bracketed language in subsection (3)(c)
15 terminates June 30, 2019--sec. 28, Ch. 6, Sp. L. November 2017.)"
16
17 **Section 23.** Section 33-30-102, MCA, is amended to read:
18 **"33-30-102. Application of chapter -- construction of other related laws.** (1) All health service
19 corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter,
20 other chapters and provisions of this title apply to health service corporations as follows: [section 8]; 33-2-1212;
21 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, parts 13,
22 19, and 23; Title 33, chapter 3, part 6; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1,
23 15, 18, 19, 22, and 32, except 33-22-111.
24 (2) A law of this state other than the provisions of this chapter applicable to health service corporations
25 must be construed in accordance with the fundamental nature of a health service corporation, and in the event
26 of a conflict, the provisions of this chapter prevail."
27
28 **Section 24.** Section 39-12-101, MCA, is amended to read:
29 **"39-12-101. ~~(Temporary)~~ Montana HELP Act workforce development -- legislative findings --**
30 **purpose.** (1) The legislature finds that:

1 (a) Montana has a disproportionately high number of individuals who are eligible for medicaid compared
2 to surrounding states;
3 (b) Montanans value independence and self-sufficiency;
4 (c) investing in Montana citizens is a legislative priority;
5 (d) participants in the HELP Act program are largely low-wage workers; and
6 (e) an opportunity exists to match individuals who need self-sustaining employment with the jobs the
7 economy needs, including newly created health care jobs.
8 (2) The purpose of this chapter is to create a collaborative effort between the department of labor and
9 industry and the department of public health and human services to:
10 (a) identify workforce development opportunities for program participants;
11 (b) gather information from state agencies on existing workforce development programs and
12 opportunities; and
13 (c) establish a comprehensive plan for coordinating efforts and resources to provide workforce
14 development opportunities.
15 (3) The department of labor and industry shall implement a workforce development program that:
16 (a) focuses on specific labor force needs within the state of Montana;
17 (b) has the goal of reducing the number of people depending on social programs, including the HELP
18 Act program; ~~and~~
19 (c) provides grants to employers who hire and train program participants; and
20 ~~(c)~~(d) increases the earning capacity, economic stability, and self-sufficiency of program participants so
21 that, among other benefits, they are able to purchase their own health insurance coverage. ~~(Terminates June 30,~~
22 ~~2019--sec. 28, Ch. 368, L. 2015.)~~"
23
24 **Section 25.** Section 39-12-103, MCA, is amended to read:
25 **"39-12-103. ~~(Temporary)~~ Montana HELP Act workforce development -- participation -- report.** (1)
26 The department shall provide individuals receiving assistance for health care services pursuant to Title 53,
27 chapter 6, part 13, with the option of participating in an employment or reemployment assessment and in the
28 workforce development program provided for in 39-12-101. The assessment must identify any probable barriers
29 to employment that exist for the member.
30 (2) (a) The department shall notify the department of public health and human services when a

1 participant has received all services and assistance under subsection (1) that can reasonably be provided to the
2 individual.
3 (b) The department is not required to provide further services under this section after it has provided the
4 notification provided for in subsection (2)(a).
5 (c) A participant who is no longer receiving services under this section does not meet the criteria of
6 53-6-1307(6)(c) for the exemption granted under 53-6-1307(6).
7 (3) The department shall report the following information to the ~~oversight committee provided for in~~
8 ~~53-6-1316~~ legislative finance committee and the children, families, health, and human services interim committee:
9 (a) the activities undertaken to establish a workforce development program for program participants and
10 the employer grant program provided for in [section 9]; ~~and~~
11 (b) the number of participants in the workforce development program and the number of participants who
12 have obtained employment or higher-paying employment;
13 (c) the number of employers receiving grant awards and the number and types of activities, training, or
14 jobs the employers provided; and
15 (d) the total cost of providing workforce development services under this chapter, including related
16 administrative costs.
17 (4) To the extent possible, the department of public health and human services shall offset the cost of
18 workforce development activities provided under this section by using temporary assistance for needy families
19 reserve funds.
20 (5) The department shall reduce fraud, waste, and abuse in determining and reviewing eligibility for
21 unemployment insurance benefits by enhancing technology system support to provide knowledge-based
22 authentication for verifying the identity and employment status of individuals seeking benefits, including the use
23 of public records to confirm identity and to flag changes in demographics. ~~(Terminates June 30, 2019--sec. 28,~~
24 ~~Ch. 368, L. 2015.)~~"
25
26 **Section 26.** Section 39-71-2375, MCA, is amended to read:
27 **"39-71-2375. Operation of state fund as authorized insurer -- issuance of certificate of authority**
28 **-- exceptions -- use of calendar year -- risk-based capital -- reporting requirements.** (1) The state fund
29 provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the
30 provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and

1 the provisions of Title 39, chapter 71, part 23.
2 (2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers'
3 compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section
4 the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously
5 renewed by the commissioner.
6 (b) The state fund shall pay the tax on net premiums under 33-2-705 and the annual fee under 33-2-708,
7 provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available
8 documentation and information that is provided by other insurers when applying for a certificate of authority under
9 33-2-115.
10 (c) The state fund is subject to the reporting requirements under 33-2-705 ~~but is not subject to the tax~~
11 ~~on net premiums~~.
12 (3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers
13 pursuant to 39-71-2313, is not subject to:
14 (i) formation requirements of an insurer under Title 33, chapter 3;
15 (ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or
16 any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;
17 (iii) liquidation or dissolution under Title 33;
18 (iv) participation in the guaranty association provided for in Title 33, chapter 10;
19 (v) 33-12-104; or
20 (vi) any assessment of punitive or exemplary damages.
21 (b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).
22 (4) The state fund shall complete financial reporting and accounting on a calendar year basis.
23 (5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in
24 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the
25 legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and
26 to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory
27 implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the
28 commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's
29 corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders
30 issued by the commissioner.

1 (b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may
2 initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to
3 comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may
4 institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for
5 rehabilitation based on the grounds provided in 33-2-1321(1) or (2).
6 (6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary
7 staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner
8 qualified by education, training, experience, and high professional competence to examine the state fund
9 pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the
10 commissioner.
11 (7) For the purposes of this section, the term "guaranteed market" has the definition provided in
12 39-71-2312."
13
14 **Section 27.** Section 53-4-1110, MCA, is amended to read:
15 **"53-4-1110. Exemption from resource test.** An otherwise applicable eligibility resource test provided
16 for in 53-6-113(6) and 53-6-131~~(7)~~(8) does not apply to plan applicants."
17
18 **Section 28.** Section 53-4-1115, MCA, is amended to read:
19 **"53-4-1115. Special revenue account.** (1) There is an account in the state special revenue fund to the
20 credit of the department for the purposes provided in subsection (2). There must be paid into the account the
21 amounts collected under 33-2-708(3)(b)(ii). Any interest or income derived from the account must be deposited
22 in the account.
23 (2) Money in the account:
24 (a) is to be used solely to cover the number of additional enrollees in the plan that exceeds the number
25 of enrollees as of November 4, 2008, within the limits provided in 53-4-1004, 53-6-131, and this part, and to cover
26 the costs of enrollment, including premium assistance, under 53-4-1108(1), and to pay administrative costs
27 associated with expanded eligibility, and to establish and maintain a reserve; and
28 (b) may be used only to match federal funds available under the children's health insurance program and
29 the Montana medicaid program.
30 (3) The unexpended balance of an appropriation from the account must remain in the account and may

be used only for the purposes stated in subsection (2).

(4) The special revenue account does not affect and is not exclusive of any other sources of funding for the programs described in 53-4-1104(2), including the special revenue account provided for in 53-4-1012.

(5) If the department determines that there is insufficient funding for the purposes of subsection (2), it may reduce eligibility requirements for participants in the children's health insurance program as provided in 53-4-1004(4)."

Section 29. Section 53-6-131, MCA, is amended to read:

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a ~~person~~ <u>U.S. citizen or a qualified alien as defined in 8 U.S.C. 1641</u> who is determined by the department of public health and human services <u>to be a Montana resident and</u>, in its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess of the applicable medical assistance limits.

(b) The person would be eligible for assistance under the program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under the program in subsection (1)(a).

(d) The person is:

(i) under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs; or

(ii) under 18 years of age and is in a guardianship subsidized by the department pursuant to 41-3-444.

(e) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(d) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically

1 needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the
2 department the amount by which the person's income exceeds the medically needy income level specified for
3 federally aided categories of assistance; and
4 (B) (I) in the case of a person who meets the nonfinancial criteria for medical assistance because the
5 person is aged, blind, or disabled, has resources that do not exceed the resource standards of the federal
6 supplemental security income program; or
7 (II) in the case of a person who meets the nonfinancial criteria for medical assistance because the person
8 is pregnant, is an infant or child, or is the caretaker of an infant or child, has resources that do not exceed the
9 resource standards adopted by the department.
10 (f) The person is a qualified pregnant woman or a child as defined in 42 U.S.C. 1396d(n).
11 (g) The person is under 19 years of age and lives with a family having a combined income that does not
12 exceed 185% of the federal poverty level. The department may establish lower income levels to the extent
13 necessary to maximize federal matching funds provided for in 53-4-1104.
14 (2) The department shall require an applicant to provide proof of the applicant's residency in this state.
15 ~~(2)~~(3) (a) The department may establish income and resource limitations. Limitations of income and
16 resources must be within the amounts permitted by federal law for the medicaid program. Any otherwise
17 applicable eligibility resource test prescribed by the department does not apply to enrollees in the healthy
18 Montana kids plan provided for in 53-4-1104.
19 (b) The department may not count as a resource an individual retirement account that was established
20 by a person participating in the medicaid program for workers with disabilities provided for in 53-6-195 if:
21 (i) the person is no longer eligible for coverage under 53-6-195; and
22 (ii) the individual retirement account was established during the time the person was receiving benefits
23 through the medicaid program for workers with disabilities.
24 ~~(3)~~(4) The Montana medicaid program shall pay, as required by federal law, the premiums necessary
25 for medicaid-eligible persons participating in the medicare program and may, within the discretion of the
26 department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified
27 medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the
28 federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:
29 (a) has income that does not exceed income standards as may be required by the Social Security Act;
30 and

(b) has resources that do not exceed standards that the department determines reasonable for purposes of the program.

~~(4)~~(5) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

~~(5)~~(6) In accordance with waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may grant eligibility for basic medicaid benefits as described in 53-6-101 to an individual receiving section 1931 medicaid benefits, as defined in 53-4-602, as the specified caretaker relative of a dependent child under the section 1931 medicaid program. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.

~~(6)~~(7) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

~~(7)~~(8) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed income standards adopted by the department that comply with the requirements of 42 U.S.C. 1396a(l)(2)(A)(i) and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

~~(8)~~(9) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.

~~(9)~~(10) A person described in subsection ~~(7)~~(8) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through (e)(7).

~~(10)~~(11) Full medical assistance under the Montana medicaid program may be granted to an individual during the period in which the individual requires treatment of breast or cervical cancer, or both, or of a precancerous condition of the breast or cervix, if the individual:

(a) has been screened for breast and cervical cancer under the Montana breast and cervical health program funded by the centers for disease control and prevention program established under Title XV of the Public Health Service Act, 42 U.S.C. 300k, or in accordance with federal requirements;

1 (b) needs treatment for breast or cervical cancer, or both, or a precancerous condition of the breast or
2 cervix;
3 (c) is not otherwise covered under creditable coverage, as provided by federal law or regulation;
4 (d) is not eligible for medical assistance under any mandatory categorically needy eligibility group; and
5 (e) has not attained 65 years of age.
6 ~~(11)~~(12) Subject to the limitation in 53-6-195, the department shall provide medicaid coverage to workers
7 with disabilities as provided in 53-6-195 and in accordance with 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII) and (r)(2) and
8 42 U.S.C. 1396o."
9
10 **Section 30.** Section 53-6-133, MCA, is amended to read:
11 **"53-6-133. Eligibility determination -- verification -- provision of benefits.** (1) The local office of
12 public assistance shall promptly determine the eligibility of each applicant under this part in accordance with the
13 rules of the department. Each applicant must be informed of the right to a fair hearing and of the confidential
14 nature of the information given. The department, through the local office of public assistance, shall, after the
15 hearing, determine whether or not the applicant is eligible for assistance under this part, and aid must be
16 furnished promptly to eligible persons. Each applicant must receive written notice of the decision concerning the
17 applicant's application, and the right of appeal is secured to the applicant under the procedures of 53-2-606.
18 (2) The local office of public assistance and the department may accept the federal social security
19 administration's determination of eligibility for supplemental security income, Title XVI of the Social Security Act,
20 as qualifying the eligible individuals to receive medical assistance under this part.
21 (3) The department shall verify the information provided on an application for medicaid under this part
22 or under part 13, using data sources allowed under federal law or regulation, to confirm an applicant's eligibility
23 for the program before authorizing payment of benefits under the program.
24 (4) The department shall establish by rule the documents to be used to verify that an applicant is a
25 Montana resident."
26
27 **Section 31.** Section 53-6-149, MCA, is amended to read:
28 **"53-6-149. State special revenue fund account -- administration.** (1) There is a hospital medicaid
29 reimbursement account in the state special revenue fund provided for in 17-2-102.
30 (2) All money collected under 15-66-102, except for the money deposited pursuant to 15-66-102(3)(b)

1 into the Montana HELP Act special revenue account provided for in [section 6], must be deposited in the account.
2 (3) Money in the account must be used by the department of public health and human services to provide
3 funding no later than May 5 of each year for increases in medicaid payments to hospitals and for the costs of
4 collection of the fee and other administrative activities associated with the implementation of increases in the
5 medicaid payments to hospitals."
6
7 **Section 32.** Section 53-6-160, MCA, is amended to read:
8 **"53-6-160. Truthfulness, completeness, and accuracy of submissions to medicaid agencies.** (1)
9 (a) A person who submits to a medicaid agency an application, claim, report, document, or other information that
10 is or may be used to determine eligibility for medicaid benefits, eligibility to participate as a provider, or the right
11 to or the amount of payment under the medicaid program is considered to represent to the department, to the
12 best of the person's knowledge and belief, that the item is genuine and that its contents, including all statements,
13 claims, and representations contained in the document, are true, complete, accurate, and not misleading.
14 (b) This section applies to the self-attestation of program participants claiming an exemption from
15 community engagement requirements under [section 1] and to the self-reporting of community engagement
16 requirements required under [section 2].
17 (2) (a) A provider has a duty to exercise reasonable care to ensure the truthfulness, completeness, and
18 accuracy of all applications, claims, reports, documents, and other information and of all statements and
19 representations made or submitted, or authorized by the provider to be made or submitted, to the department for
20 purposes related to the medicaid program. The duty applies whether the applications, claims, reports, documents,
21 other information, statements, or representations were made or submitted, or authorized by the provider to be
22 made or submitted, on behalf of the provider or on behalf of an applicant or recipient being served by the provider.
23 (b) A provider has a duty to exercise reasonable care to ensure that a claim made or submitted to the
24 department or its agents or employees for payment or reimbursement under the medicaid program is one for
25 which the provider is entitled to receive payment and that the service or item is provided and billed according to
26 all applicable medicaid requirements, including but not limited to identification of the appropriate procedure code
27 or level of service and provision of the service by a person, facility, or other provider entitled to receive medicaid
28 payment for the particular service.
29 (3) A person is considered to have known that a claim, statement, or representation related to the
30 medicaid program was false if the person knew, or by virtue of the person's position, authority, or responsibility

1 should have known, of the falsity of the claim, statement, or representation.
2 (4) A person is considered to have made or to have authorized to be made a claim, statement, or
3 representation if the person:
4 (a) had the authority or responsibility to:
5 (i) make the claim, statement, or representation;
6 (ii) supervise another who made the claim, statement, or representation; or
7 (iii) authorize the making of the claim, statement, or representation, whether by operation of law, business
8 or professional practice, or office policy or procedure; and
9 (b) exercised or failed to exercise that authority or responsibility and, as a direct or indirect result, the
10 false statement was made, resulting in a claim for a service or item when the person knew or had reason to know
11 that the person was not entitled under applicable statutes, regulations, rules, or policies to medicaid payment or
12 benefits for the service or item or for the amount of payment requested or claimed.
13 (5) (a) There is an inference that a person who signs or submits a document to a medicaid agency on
14 behalf of or in the name of a provider is authorized by the provider to do so and is acting under the provider's
15 direction.
16 (b) For purposes of this section, the term "signs" includes but is not limited to the use of facsimile,
17 computer-generated and typed, or block-letter signatures.
18 (6) The department shall directly or by contract provide a program of instruction and assistance to
19 persons submitting applications, claims, reports, documents, and other information to the department concerning
20 the completion and submission of the application, claim, report, document, or other information in a manner
21 determined necessary by the department. The program must include:
22 (a) clear directions for the completion of applications, claims, reports, documents, and other information;
23 (b) examples of properly completed applications, claims, reports, documents, and other information;
24 (c) a method by which persons submitting applications, claims, reports, documents, and other
25 information may, on a case-by-case basis, receive accurate, complete, specific, and timely advice and directions
26 from the department before the completed applications, claims, reports, documents, and other information must
27 be submitted to the department; and
28 (d) a method by which persons submitting applications, claims, reports, documents, and other
29 information may challenge the department's interpretation or application of the manner in which the applications,
30 claims, reports, documents, and other information must be completed.

1 (7) This section applies only for the purpose of civil liability under Title 53 and does not apply in a criminal
2 proceeding."
3
4 **Section 33.** Section 53-6-1302, MCA, is amended to read:
5 **"53-6-1302. ~~(Temporary)~~ Montana HELP Act program -- legislative findings and purpose.** (1) There
6 is a Montana Health and Economic Livelihood Partnership Act program established through a collaborative effort
7 of the department of public health and human services and the department of labor and industry to:
8 (a) provide coverage of health care services for low-income Montanans;
9 (b) improve the readiness of program participants to enter the workforce or obtain better-paying jobs;
10 and
11 (c) reduce the dependence of Montanans on public assistance programs.
12 (2) The legislature finds that improving the delivery of health care services to Montanans requires state
13 government, health care providers, patient advocates, and other parties interested in high-quality, affordable
14 health care to collaborate in order to:
15 (a) increase the availability of high-quality health care to Montanans;
16 (b) provide greater value for the tax dollars spent on the Montana medicaid program;
17 (c) reduce health care costs;
18 (d) provide incentives that encourage Montanans to take greater responsibility for their personal health;
19 (e) boost Montana's economy by reducing the costs of uncompensated care; and
20 (f) reduce or minimize the shifting of payment for unreimbursed health care costs to patients with health
21 insurance.
22 (3) The legislature further finds that providing greater value for the dollars spent on the medicaid program
23 requires considering options for delivering services in a more efficient and cost-effective manner, including but
24 not limited to:
25 (a) offering incentives to encourage health care providers to achieve measurable performance outcomes;
26 (b) improving the coordination of care among health care providers who participate in the medicaid
27 program;
28 (c) reducing preventable hospital readmissions; and
29 (d) exploring methods of medicaid payment that promote quality of care and efficiencies.
30 (4) The legislature further finds that assessing workforce readiness, ~~and~~ providing necessary job training

or skill development, and establishing community engagement requirements for individuals who need assistance with health care costs could help those individuals obtain employment that has health care coverage benefits or that would allow them to purchase their own health insurance coverage.

(5) The legislature further finds that:

(a) it is important to implement additional fraud, waste, and abuse safeguards to protect and preserve the integrity of the medicaid program and the unemployment insurance program for individuals who qualify for the programs; and

(b) state policymakers have an interest in testing the effectiveness of wellness incentives in order to collect and analyze information about the correlation between wellness incentives and health status.

(6) The purposes of the act are to:

(a) modify and enhance Montana's health care delivery system to provide access to high-quality, affordable health care for all Montana citizens; and

(b) provide low-income Montanans with opportunities to improve their readiness for work or to obtain higher-paying jobs.

(7) The department of labor and industry and the department of public health and human services shall maximize the use of existing resources in administering the program. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 34. Section 53-6-1303, MCA, is amended to read:

"53-6-1303. ~~(Temporary)~~ Definitions. As used in this part, the following definitions apply:

(1) "Community engagement" means participation in the activities specified in [section 1] as a means to improve a program participant's well-being and opportunities for self-sufficiency.

~~(1)~~(2) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(2)~~(3) "HELP Act" or "act" means the Montana Health and Economic Livelihood Partnership Act provided for in Title 39, chapter 12, and this part.

~~(3)~~(4) "Member" means an individual enrolled in the Montana medicaid program pursuant to 53-6-131 or receiving medicaid-funded services pursuant to 53-6-1304.

~~(4)~~(5) "Program participant" or "participant" means an individual enrolled in the Montana Health and Economic Livelihood Partnership Act program established in Title 39, chapter 12, and this part. ~~(Terminates June~~

~~30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 35. Section 53-6-1304, MCA, is amended to read:

"53-6-1304. ~~(Temporary)~~ Montana HELP Act program -- eligibility for coverage of health care services ~~-- statutory appropriations -- federal special revenue.~~ ~~(1)~~ An individual is eligible for coverage of health care services provided pursuant to this part if the individual meets the requirements of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).

~~(2) Funds necessary to implement this part, including benefits and administrative costs, are statutorily appropriated, as provided in 17-7-502, from the general fund to the department.~~

~~(3) There is an account in the federal special revenue fund to the credit of the department for the payment of costs, including benefits and administrative costs, of providing health care services to individuals who are eligible for coverage pursuant to subsection (1).~~

~~(4) The federal medical assistance percentage received pursuant to 42 U.S.C. 1396d(y) must be deposited in the account provided for in subsection (3).~~

~~(5) Money in the account is statutorily appropriated, as provided in 17-7-502, to the department for the purpose provided in subsection (3). (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 36. Section 53-6-1305, MCA, is amended to read:

"53-6-1305. ~~(Temporary)~~ Montana HELP Act program -- delivery of health care services -- third-party administrator -- rulemaking. (1) The department ~~shall~~ may contract as provided in Title 18, chapter 4, with one or more third-party administrators to assist in administering the delivery of health care services to members eligible under 53-6-1304, including but not limited to:

(a) establishing networks of health care providers;

(b) paying claims submitted by health care providers;

(c) collecting the premiums provided for in 53-6-1307;

(d) coordinating care;

(e) helping to administer the program; and

(f) helping to administer the medicaid program reforms as specified in 53-6-1311.

(2) ~~The~~ If the department decides to contract with a third-party administrator, the department shall determine the basic health care services to be provided through the arrangement with ~~a~~ the third-party

1 administrator.
2 (3) (a) The department may exempt certain individuals who are eligible for medicaid-funded services
3 pursuant to 53-6-1304 from receiving health care services through ~~the~~ an arrangement with a third-party
4 administrator if the individuals would be served more appropriately through the medical assistance program
5 established in Title 53, chapter 6, part 1, because the individuals:
6 (i) have exceptional health care needs, including but not limited to medical, mental health, or
7 developmental conditions;
8 (ii) live in a geographical area, including an Indian reservation, for which the third-party administrator has
9 been unable to make arrangements with sufficient health care providers to offer services to the individuals;
10 (iii) need continuity of care that would not be available or cost-effective through the arrangement with the
11 third-party administrator; or
12 (iv) are otherwise exempt under federal law.
13 (b) ~~The~~ If the department contracts with a third-party administrator, the department shall:
14 (i) adopt rules establishing criteria for determining whether a member is exempt from receiving health
15 care services through an arrangement with ~~a~~ the third-party administrator; ~~and~~
16 (ii) provide coverage for exempted individuals through the medical assistance program established in Title
17 53, chapter 6, part 1~~.~~; and
18 ~~(4)~~(iii) ~~For~~ for members participating in the arrangement with ~~the~~ a third-party administrator, ~~the~~
19 ~~department shall~~ directly cover any service required under federal or state law that is not available through the
20 arrangement with the third-party administrator.
21 ~~(5) The department shall:~~
22 ~~(a) seek federal authorization from the U.S. department of health and human services through a waiver~~
23 ~~authorized by 42 U.S.C. 1315 and other waivers or through other means, as may be necessary, to implement~~
24 ~~all of the provisions of Title 39, chapter 12, and this part; and~~
25 ~~(b) implement access to the health care services in accordance with the requirements necessary to~~
26 ~~receive the federal medical assistance percentage provided for by 42 U.S.C. 1396d(y).~~
27 (4) The department may contract with a third-party administrator for the services allowed under
28 subsections (1)(a) through (1)(f) only upon receipt of a federal waiver allowing a third-party administrator to
29 provide services in accordance with this part.
30 ~~(6) The department may provide medicaid-funded services to members eligible pursuant to 53-6-1304~~

~~only upon federal approval of any necessary waivers.(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 37. Section 53-6-1306, MCA, is amended to read:

"53-6-1306. ~~(Temporary) Copayments -- exemptions -- report~~ Prohibition on copayments. ~~(1) A program participant shall make copayments to health care providers for health care services received pursuant to this part.~~ The department may not require a program participant to make a copayment, to pay a coinsurance amount, or to meet a deductible amount for any service covered under this part.

~~(2) Except as provided in subsection (3), the department shall adopt a copayment schedule that reflects the maximum copayment amount allowed under federal law. The total amount of copayments collected under this section must be capped at the maximum amount allowed by federal law and regulations.~~

~~(3) The department may not require a copayment for:~~

~~(a) preventive health care services;~~

~~(b) generic pharmaceutical drugs;~~

~~(c) immunizations provided according to a schedule established by the department that reflects guidelines issued by the centers for disease control and prevention; or~~

~~(d) medically necessary health screenings ordered by a health care provider.~~

~~(4) Each health care provider participating in the third-party arrangement shall report the following information annually to the oversight committee on the Montana Health and Economic Livelihood Partnership Act:~~

~~(a) the total amount of copayments that the provider was unable to collect from participants; and~~

~~(b) the efforts the health care provider made to collect the copayments. (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 38. Section 53-6-1307, MCA, is amended to read:

"53-6-1307. ~~(Temporary)~~ Premiums -- collection of overdue premiums -- nonpayment as voluntary disenrollment -- reenrollment -- exemptions. (1) (a) A program participant shall pay an annual premium, billed monthly, equal to ~~2%~~ a percentage of the participant's modified adjusted gross income as determined in accordance with 42 U.S.C. 1396a(e)(14). The premiums must:

(i) be set at 2% of a participant's income in the first 2 years the participant receives coverage under this part; and

(ii) increase by 0.5% in each subsequent year that a participant receives coverage, up to a maximum of

1 5% of the participant's income.
2 (b) Premiums paid pursuant to this section must be deposited in the ~~general fund~~ Montana HELP Act
3 special revenue account provided for in [section 6].
4 (2) Within 30 days of a participant's failure to make a required payment, the ~~third-party administrator~~
5 department or a third-party administrator administering the program, if any, shall notify the participant ~~and the~~
6 ~~department~~ that payment is overdue and that all overdue premiums must be paid within 90 days of the date the
7 notification was sent.
8 (3) (a) If a participant with an income of 100% of the federal poverty level or less fails to make payment
9 for overdue premiums, the department shall provide notice to the department of revenue of the participant's failure
10 to pay. The department of revenue shall collect the amount due for nonpayment by assessing the amount against
11 the participant's annual income tax in accordance with Title 15, chapters 1 and 30.
12 (b) The debt remains until paid and may be collected through assessments against future income tax
13 returns or through a civil action initiated by the state.
14 (4) If a participant with an income of more than 100% but not more than 138% of the federal poverty level
15 fails to make the overdue payments within 90 days of the date the notification was sent, the department shall:
16 (a) follow the procedure established in subsection (3) for collection of the unpaid premiums; and
17 (b) consider the failure to pay to be a voluntary disenrollment from the program. The department may
18 reenroll a participant in the program upon payment of the total amount of overdue payments.
19 (5) If a participant who has failed to pay the premiums does not indicate that the participant no longer
20 wishes to participate in the program, the department may reenroll the person in the program when the department
21 of revenue assesses the unpaid premium through the participant's income taxes.
22 (6) Participants who meet two of the following criteria are not subject to the voluntary disenrollment
23 provisions of this section:
24 (a) discharge from United States military service within the previous 12 months;
25 (b) enrollment for credit in any Montana university system unit, a tribal college, or any other accredited
26 college within Montana offering at least an associate degree, subject to the provisions of subsection (7);
27 (c) participation in a workforce program or activity established under Title 39, chapter 12; or
28 (d) participation in any of the following healthy behavior plans developed by a health care provider or
29 third-party administrator, if any, or approved by the department:
30 (i) a medicaid health home;

1 (ii) a patient-centered medical home;
2 (iii) a cardiovascular disease, obesity, or diabetes prevention program;
3 (iv) a program restricting the participant to obtaining primary care services from a designated provider
4 and obtaining prescriptions from a designated pharmacy;
5 (v) a medicaid primary care case management program established by the department;
6 (vi) a tobacco use prevention or cessation program;
7 (vii) a medicaid waiver program providing coverage for family planning services;
8 (viii) a substance abuse treatment program; or
9 (ix) a care coordination or health improvement plan administered by the third-party administrator.
10 (7) A participant seeking an exemption under subsection (6) is not eligible for the education exemption
11 provided for in subsection (6)(b) for more than 4 years. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"
12
13 **Section 39.** Section 53-6-1311, MCA, is amended to read:
14 **"53-6-1311. ~~(Temporary)~~ Medicaid program reforms.**(1) To ensure that the Montana medicaid
15 program is administered efficiently and effectively, the department shall strengthen existing programs that
16 manage the way members obtain approval for medical services and shall establish additional programs designed
17 to reduce costs and improve medical outcomes. The efforts may include but are not limited to:
18 (a) establishing by rule requirements designed to strengthen the relationship between physicians and
19 members enrolled in existing primary care case management programs;
20 (b) strengthening data-sharing arrangements with providers to reduce inappropriate use of emergency
21 room services and overuse of other services;
22 (c) expanding to additional members any existing programs in which case managers and providers work
23 with members with high-risk medical conditions to provide preventive care and advice and to make referrals for
24 medical services;
25 (d) establishing, within existing funds, one or more pilot programs to improve the health of members,
26 including but not limited to efforts to increase pain management, decrease emergency department overuse, and
27 prevent drug or alcohol addiction or abuse;
28 (e) reviewing existing primary care case management programs to evaluate and improve their
29 effectiveness; and
30 ~~(f) reducing fraud, waste, and abuse in the medicaid program before, during, and after enrollment by~~

~~enhancing technology system support to provide knowledge-based authentication for verifying the identity and financial status of individuals seeking benefits, including the use of public records to confirm identity and flag changes in demographics; and~~

~~(g)~~(f) engaging members with chronic or other medical or behavioral health conditions in coordinated care models that more closely monitor and manage a member's health to reduce costs or improve medical outcomes. These coordinated care models may include but are not limited to:

(i) patient-centered medical homes;

(ii) accountable care organizations;

(iii) managed care organizations as defined in 42 CFR 438.2;

(iv) health improvement programs;

(v) health homes for behavioral health or other chronic conditions; and

(vi) changes to current service delivery methods.

(2) The department shall work to reduce fraud, waste, and abuse in the medicaid program before, during, and after enrollment by enhancing technology system support to provide knowledge-based authentication for verifying the identity and financial status of individuals seeking benefits, including the use of public records to confirm identity and flag changes in demographics.

~~(2)~~(3) The department may ask a third-party administrator under contract with the department to assist in efforts undertaken pursuant to ~~subsection (1)~~ subsections (1) and (2) when the activity can appropriately be handled by ~~the~~ a third-party administrator.

~~(3)~~(4) A care coordination entity used to deliver medicaid services shall meet all state standards for operation, including but not limited to solvency, consumer protection, nondiscrimination, network adequacy, care model design, and fraud and abuse standards. ~~(Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 40. Section 53-6-1317, MCA, is amended to read:

"53-6-1317. ~~(Temporary) Duties of Montana HELP Act oversight committee -- reports~~ Report to legislature. ~~(1) To provide reports and make recommendations to the legislature, the oversight committee on the Montana Health and Economic Livelihood Partnership Act shall review:~~

~~(a) data from and activities by the department of public health and human services and the department of labor and industry related to the health care and workforce development activities undertaken pursuant to the HELP Act;~~

~~(b) the Montana medicaid program; and~~

~~(c) the delivery of health care services in Montana.~~

~~(2)~~ The ~~departments~~ department shall report the following information to the ~~oversight~~ legislative finance committee and the children, families, health, and human services interim committee quarterly:

~~(a)~~(1) the number of individuals who were determined eligible for medicaid-funded services pursuant to 53-6-1304;

~~(b)~~(2) demographic information on program participants;

~~(c)~~(3) the average length of time that participants remained eligible for medical assistance;

~~(d) the number of participants who completed an employment or reemployment assessment;~~

~~(e) the number of participants who took part in workforce development activities;~~

~~(f)~~(4) the number of participants subject to the ~~fee~~ fees provided for in 15-30-2660 and the total amount of fees collected;

(5) the amount of money deposited in the Montana HELP act special revenue account, by source of funding;

~~(g)~~(6) the level of participant engagement in wellness activities or incentives offered ~~by health care providers or the third-party administrator~~ under this part;

(7) the number of participants who took part in community engagement activities and the number who were disenrolled for failure to take part in community engagement activities;

~~(h)~~(8) the number of participants who reduced their dependency on the HELP Act program, either voluntarily or because of increased income levels; and

~~(i)~~(9) the total cost of providing services under ~~Title 39, chapter 12, and~~ this part, including related administrative costs.

~~(3) The committee shall review and provide comment on administrative rules proposed for carrying out activities under Title 39, chapter 12, and this part. The committee may ask the appropriate administrative rule review committee to object to a proposed rule as provided in 2-4-406.~~

~~(4) The committee shall:~~

~~(a) review how implementation of the act is being carried out, including the collection of copayments and premiums for health care services;~~

~~(b) evaluate how health care services are delivered and whether new approaches could improve delivery of care, including but not limited to the use of medical homes and coordinated care organizations;~~

~~(c) review ideas to reduce or minimize the shifting of the payment of unreimbursed health care costs to patients with health insurance;~~

~~(d) evaluate whether providing incentives to health care providers for meeting measurable benchmarks may improve the delivery of health care services;~~

~~(e) review options for reducing the inappropriate use of emergency department services;~~

~~(f) review ways to monitor for the excessive or inappropriate use of prescription drugs;~~

~~(g) examine ways to:~~

~~(i) promote the appropriate use of health care services, particularly laboratory and diagnostic imaging services;~~

~~(ii) increase the availability of mental health services;~~

~~(iii) reduce fraud and waste in the medicaid program; and~~

~~(iv) improve the sharing of data among health care providers to identify patterns in the use of health care services across payment sources;~~

~~(h) receive regular reports from the department on the department's efforts to pursue contracting options for administering services to members eligible for medicaid-funded services pursuant to 53-6-1304;~~

~~(i) coordinate its efforts with any legislative committees that are working on matters related to health care and the delivery of health care services; and~~

~~(j) recommend future funding options for the HELP Act program to future legislatures.~~

~~(5) The committee shall summarize and present its findings and recommendations in a final report to the governor and to the legislative finance committee no later than August 15 of each even-numbered year. Copies of the report must be provided to the children, families, health, and human services interim committee. (Terminates June 30, 2019--sec. 28, Ch. 368, L. 2015.)~~"

Section 41. Section 28, Chapter 368, Laws of 2015, is amended to read:

"**Section 28. Termination.** (1) [This act] terminates ~~June 30, 2019~~ December 31, 2019.

(2) The department may reapply for the same waiver received to implement the Montana Health and Economic Livelihood Partnership Act program if the waiver expires before ~~June 30, 2019~~ December 31, 2019."

NEW SECTION. **Section 42. Repealer.** The following section of the Montana Code Annotated is repealed:

1 53-6-1316. Montana HELP Act oversight committee -- membership.
2
3 NEW SECTION. **Section 43. Repealer.** Section 28, Chapter 368, Laws of 2015, is repealed.
4
5 NEW SECTION. **Section 44. Appropriations.** (1) There is appropriated $3.5 million from the Montana
6 HELP Act special revenue account provided for in [section 6] to the department of labor and industry for the
7 biennium beginning July 1, 2019, for the HELP Act employer grant program provided for in [section 9].
8 (2) The following amounts are appropriated to the department of public health and human services for
9 the biennium beginning July 1, 2019, for the payment of costs, including benefits and administrative costs, of
10 providing health care services to individuals who are eligible for coverage under Title 53, chapter 6, part 13:

11	Fiscal Year 2020	$678,185,000	federal special revenue
12		$29,510,000	general fund
13		$30,000,000	state special revenue
14	Fiscal Year 2021	$685,606,000	federal special revenue
15		$36,667,000	general fund
16		$30,000,000	state special revenue

17 (3) The following amounts are appropriated to the department of public health and human services for
18 the biennium beginning July 1, 2019, for the payment of costs, including administrative costs, of providing health
19 care services to individuals who are eligible for coverage of health care costs under Title 53, chapter 6, part 1 or
20 part 13.

21	Fiscal year 2020	$110,000,000	federal special revenue
22		$25,000,000	state special revenue
23	Fiscal year 2021	$110,000,000	federal special revenue
24		$25,000,000	state special revenue

25 (4) (a) Money from the Montana HELP Act special revenue account provided for in [section 6] must be
26 used for the state special revenue appropriated under subsection (2).
27 (b) Money from the special revenue account provided for in 53-6-149 must be used for the state special
28 revenue appropriated under subsection (3).
29
30 NEW SECTION. **Section 45. Transition -- direction to department of public health and human**

1 **services -- notification to legislature.** (1) The legislature directs the department of public health and human
2 services to notify the centers for medicare and medicaid services that passage and approval of [this act]
3 constitutes legislative authorization to continue the current research and demonstration project approved under
4 waiver No. 11-W00300/8 for the Montana Health and Economic Livelihood Partnership (HELP) Program
5 Demonstration through December 31, 2020.
6 (2) The legislature directs the department of public health and human services to:
7 (a) apply no later than August 30, 2019, to the centers for medicare and medicaid services for any
8 waivers needed to implement the provisions of [this act]; and
9 (b) carry out any activities before August 30, 2019, that are needed in order to develop and submit waiver
10 proposals by August 30, 2019, including but not limited to:
11 (i) presenting any section 1115 waiver proposals to the medicaid advisory council and the children,
12 families, health, and human services interim committee prior to submission to the centers for medicare and
13 medicaid services, as required under 53-2-215;
14 (ii) providing for a public comment period at least 60 days before submission as required under 53-2-215;
15 and
16 (iii) complying with any other public comment provisions required under federal law or regulation.
17 (3) The legislature directs the department of public health and human services to notify individuals
18 enrolled in medicaid pursuant to Title 53, chapter 6, part 13, of the proposed changes to the program and the time
19 periods within which the individuals would have to comply with the requirements of [this act] if the centers for
20 medicare and medicaid services approves any waivers submitted to carry out the provisions of [this act].
21 Notification may be made at the time any waiver proposal is submitted or approved, at the department's
22 discretion.
23 (4) The director of the department shall notify the legislative finance committee and the children, families,
24 health, and human services interim committee of:
25 (a) the date on which waiver approval is received or denied; and
26 (b) if waiver approval is received, the date on which the community engagement requirements are
27 implemented.
28
29 NEW SECTION. **Section 46. Notification to tribal governments.** The secretary of state shall send
30 a copy of [this act] to each tribal government located on the seven Montana reservations and to the Little Shell

1 Chippewa tribe.
2
3 NEW SECTION. **Section 47. Codification instruction.** (1) [Sections 1 through 6] are intended to be
4 codified as an integral part of Title 53, chapter 6, part 13, and the provisions of Title 53, chapter 6, part 13, apply
5 to [sections 1 through 6].
6 (2) [Section 7] is intended to be codified as an integral part of Title 27, chapter 1, part 7, and the
7 provisions of Title 27, chapter 1, part 7, apply to [section 7].
8 (3) [Section 8] is intended to be codified as an integral part of Title 33, chapter 2, part 7, and the
9 provisions of Title 33, chapter 2, part 7, apply to [section 8].
10 (4) [Section 9] is intended to be codified as an integral part of Title 39, chapter 12, and the provisions
11 of Title 39, chapter 12, apply to [section 9].
12
13 NEW SECTION. **Section 48. Nonseverability.** It is the intent of the legislature that each part of [this
14 act] is essentially dependent upon every other part, and if one part is held unconstitutional or invalid, all other
15 parts are invalid.
16
17 NEW SECTION. **Section 49. Contingent voidness -- notification to code commissioner.** (1) If the
18 centers for medicare and medicaid services fails to approve the waivers needed to implement the provisions of
19 [sections 1, 2, and 5] in the manner approved by the legislature, then [this act] is void.
20 (2) If the centers for medicare and medicaid services fails to provide any waivers necessary to implement
21 the premium provisions of [section 38(1)], then the amendments to 53-6-1307(1) in [section 38(1)] are void.
22 (3) The director of the department shall notify the code commissioner of the occurrence of any
23 determination made under this section and the date of the occurrence.
24
25 NEW SECTION. **Section 50. Effective dates.** (1) Except as provided in subsections (2) through (4),
26 [this act] is effective July 1, 2019.
27 (2) [Section 7] is effective October 1, 2019.
28 (3) [Sections 1 through 5 and sections 33, 34, 37, 38, 39, and 43] are effective January 1, 2020.
29 (4) [Sections 40 through 42, 45 through 49, and 51] and this section are effective on passage and
30 approval.

1
2 NEW SECTION. **Section 51. Applicability.** An individual enrolled in the expanded medicaid program
3 provided for in Title 53, chapter 6, part 13, on the date the centers for medicare and medicaid services approves
4 a waiver authorizing community engagement requirements and health risk and employment readiness
5 assessments shall:
6 (1) complete the health risk and employment readiness assessments within 6 months of approval of the
7 waiver; and
8 (2) comply with the community engagement requirements of [this act] within 90 days of the date the
9 department of public health and human services has implemented the community engagement requirements.
10 - END -