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PRIMARY CARE NETWORK AMENDMENTS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Steve Eliason

Senate Sponsor: _____

LONG TITLE

General Description:

This bill creates a new waiver program to provide enhanced benefits for certain individuals who qualify for coverage in the Primary Care Network, and provides funding for the enhancement waiver program through a new hospital assessment and a portion of the growth in alcohol and tobacco tax revenues.

Highlighted Provisions:

This bill:

- directs the Department of Health to apply for a new waiver or an amendment to an existing waiver to provide enhanced benefits for certain individuals who qualify for coverage in the Primary Care Network;
- describes the enhanced benefits;
- creates a new hospital assessment to pay for the cost of the enhancement waiver program;
- dedicates a portion of the growth in the state's revenue from alcohol and tobacco taxes to pay for the cost of the enhancement waiver program; and
- sunsets the new hospital assessment.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

H.B. 325

Utah Code Sections Affected:

AMENDS:

32B-2-301, as last amended by Laws of Utah 2017, Chapter 159

59-14-204, as last amended by Laws of Utah 2016, Chapter 168

63I-1-226, as last amended by Laws of Utah 2017, Chapters 177 and 443

ENACTS:

26-18-415, Utah Code Annotated 1953

26-36c-101, Utah Code Annotated 1953

26-36c-102, Utah Code Annotated 1953

26-36c-103, Utah Code Annotated 1953

26-36c-201, Utah Code Annotated 1953

26-36c-202, Utah Code Annotated 1953

26-36c-203, Utah Code Annotated 1953

26-36c-204, Utah Code Annotated 1953

26-36c-205, Utah Code Annotated 1953

26-36c-206, Utah Code Annotated 1953

26-36c-207, Utah Code Annotated 1953

26-36c-208, Utah Code Annotated 1953

26-36c-209, Utah Code Annotated 1953

26-36c-210, Utah Code Annotated 1953

26-36c-211, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-415** is enacted to read:

26-18-415. Primary Care Network enhancement waiver program.

(1) As used in this section:

(a) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(b) "Federal poverty level" means the poverty guidelines established by the secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9902(2).

(c) "Income eligibility ceiling" means the percent of federal poverty level:

(i) established by the Legislature in an appropriations act adopted pursuant to Title 63J, Chapter 1, Budgetary Procedures Act; and

(ii) under which an individual may qualify for coverage in the enhancement waiver program in accordance with this section.

(d) "Optional population" means the optional expansion population under PPACA if the expansion provides coverage for individuals at or above 100% of the federal poverty level.

(e) "PPACA" means the same as that term is defined in Section 31A-1-301.

(f) "Primary Care Network" means the state primary care network program created by the Medicaid primary care network demonstration waiver obtained under Section 26-18-3.

(2) Before July 1, 2018, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to implement, within the state Medicaid program, the enhancement waiver program described in this section.

(3) An individual who is eligible for the enhancement waiver program may receive the following benefits under the enhancement waiver program:

(a) diagnostic testing and procedures;

(b) medical specialty care;

(c) inpatient hospital services;

(d) outpatient hospital services; and

(e) outpatient behavioral health care, including outpatient substance abuse care.

(4) An individual is eligible for the enhancement waiver program if, at the time of enrollment:

(a) the individual is qualified to enroll in the Primary Care Network;

(b) the individual's annual income is below the income eligibility ceiling established by the Legislature under Subsection (1)(c); and

(c) the individual meets the eligibility criteria established by the department under Subsection (5).

(5) (a) Based on available funding and approval from CMS, the department shall determine the criteria for an individual to qualify for the enhancement waiver program, based on the following priority:

(i) adults with dependent children; and

(ii) if funding is available, adults without dependent children.

(b) The number of individuals enrolled in the enhancement waiver program may not exceed 105% of the number of individuals who were enrolled in the Primary Care Network on December 31, 2017.

(6) The department may request a modification of the income eligibility ceiling and the eligibility criteria under Subsection (5) from CMS each fiscal year based on enrollment in the enhancement waiver program, projected enrollment in the enhancement waiver program, costs to the state, and the state budget.

(7) The department may implement the enhancement waiver program by contracting with Medicaid accountable care organizations to administer the enhancement waiver program.

(8) If the department and the governor expand the state's Medicaid program to the optional population under PPACA, the department:

(a) except as provided in Subsection (9), may not accept any new enrollees into the enhancement waiver program after the day on which the expansion to the optional population under PPACA is effective; and

(b) shall suspend the enhancement waiver program within one year after the day on which the expansion to the optional population under PPACA is effective.

(9) If, after the expansion to the optional population described in Subsection (8) takes effect, the expansion to the optional population is repealed by either the state or the federal government, the department shall reinstate the enhancement waiver program and continue to accept new enrollees into the enhancement waiver program in accordance with the provisions of this section.

Section 2. Section **26-36c-101** is enacted to read:

CHAPTER 36c. PRIMARY CARE NETWORK ENHANCEMENT HOSPITAL ASSESSMENT ACT

Part 1. General Provisions

26-36c-101. Title.

This chapter is known as the "Primary Care Network Enhancement Hospital Assessment Act."

Section 3. Section **26-36c-102** is enacted to read:

26-36c-102. Definitions.

As used in this chapter:

(1) "Assessment" means the primary care network enhancement hospital assessment established by this chapter.

(2) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(3) "Discharges" means the number of total hospital discharges reported on:

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

(4) "Division" means the Division of Health Care Financing within the department.

(5) "Enhancement waiver program" means the program established by the Primary Care Network enhancement waiver under Section 26-18-415.

(6) "Hospital share" means the hospital share described in Section 26-36c-203.

(7) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26-18-405.

(8) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

(9) (a) "Non-state government hospital" means a hospital owned by a non-state government entity.

(b) "Non-state government hospital" does not include:

(i) the Utah State Hospital; or

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.

(10) (a) "Private hospital" means:

(i) a general acute hospital, as defined in Section 26-21-2, that is privately owned and operating in the state; or

(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital for which inpatient admissions are predominantly for:

(A) rehabilitation;

(B) psychiatric care;

(C) chemical dependency services; or

(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment, as defined in Section 62A-2-101.

(11) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

(12) "Upper payment limit gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. Sec. 447.321.

Section 4. Section **26-36c-103** is enacted to read:

26-36c-103. Application.

(1) Other than for the imposition of the assessment described in this chapter, nothing in this chapter shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:

(a) state law;

(b) ad valorem property taxes;

(c) sales or use taxes; or

(d) other taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.

(2) All assessments paid under this chapter may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This chapter does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon a hospital; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

Section 5. Section **26-36c-201** is enacted to read:

Part 2. Assessment and Collection

26-36c-201. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:

(i) the Primary Care Network enhancement waiver under Section 26-18-415; and

(ii) the assessment under this chapter;

(b) in the amount designated in Sections 26-36c-204 and 26-36c-205; and

(c) in accordance with Section 26-36c-202.

(2) Subject to Subsection 26-36c-202(4), the assessment imposed by this chapter is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26-36c-210.

(3) The first quarterly payment is not due until at least three months after the effective date of the coverage provided through the enhancement waiver program.

Section 6. Section **26-36c-202** is enacted to read:

26-36c-202. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The collecting agent for the assessment imposed under Section 26-36c-201 is the department.

(2) The department is vested with the administration and enforcement of this chapter, and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this chapter;

(b) audit records of a facility that:

(i) is subject to the assessment imposed under this chapter; and

(ii) does not file a Medicare cost report; and

(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.

(3) The department shall:

(a) administer the assessment in this part separately from the assessments in Chapter 36a, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment Act; and

(b) deposit assessments collected under this chapter into the Primary Care Network Enhancement Fund created by Section 26-36c-208.

(4) (a) Quarterly assessments imposed by this chapter shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

(b) The department may, by rule, extend the time for paying the assessment.

Section 7. Section **26-36c-203** is enacted to read:

26-36c-203. Hospital share.

(1) The hospital share is 45% of the state's net cost of:

(a) the enhancement waiver program; and

(b) the upper payment limit gap.

(2) (a) The hospital share is capped at no more than $6,000,000 annually, consisting of:

(i) a $5,000,000 cap on the hospital share of the enhancement waiver program; and

(ii) a $1,000,000 cap on the hospital share of the upper payment limit gap.

(b) The department shall prorate the cap described in Subsection (2)(a) in any year in which the enhancement waiver program is not in effect for the full fiscal year.

(c) If the benefits in the enhancement waiver program are enhanced in a manner that is greater than the enhancement described in Section 26-18-415, the hospital share is capped at no more than 33% of the state's share of the cost of the enhancement that is in addition to the program described in Section 26-18-415.

Section 8. Section **26-36c-204** is enacted to read:

26-36c-204. Hospital financing of primary care network enhancement waiver.

(1) Private hospitals shall be assessed under this chapter for:

(a) 69% of the portion of the hospital share for the enhancement waiver program; and

(b) 100% of the portion of the hospital share for the upper payment limit gap.

(2) (a) The department shall, on or before October 15, 2019, and on or before October 15 of each subsequent year, produce a report that calculates the state's net cost of:

(i) the enhancement waiver program; and

(ii) the upper payment limit gap.

(b) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by the private hospitals shall be applied to the fiscal year in which the report is issued.

(3) A Medicaid accountable care organization shall, on or before October 15 of each year, report to the department the following data from the prior state fiscal year for each private hospital, state teaching hospital, and non-state government hospital provider that the Medicaid

accountable care organization contracts with:

(a) for the traditional Medicaid population:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

(b) if the Medicaid accountable care organization enrolls any individuals in the enhancement waiver program, for the Primary Care Network population newly eligible for the enhancement waiver program:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

Section 9. Section **26-36c-205** is enacted to read:

26-36c-205. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital in an amount calculated at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and more than 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The uniform assessment rate described in Subsection (1)(a) shall be determined by dividing the hospital share for assessed private hospitals, described in Subsection 26-36c-204(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this chapter.

(e) Any quarterly changes to the uniform assessment rate shall be applied uniformly to

all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3) (a) If a hospital's fiscal year Medicare cost report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and

(iii) failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the assessment for each hospital shall be separately calculated by the department; and

(b) each separate hospital shall pay the assessment imposed by this chapter.

(5) If multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

Section 10. Section **26-36c-206** is enacted to read:

26-36c-206. State teaching hospital and non-state government hospital mandatory

intergovernmental transfer.

(1) A state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Primary Care Network Enhancement Fund created in Section 26-36c-208, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:

(a) the Primary Care Network enhancement waiver under Section 26-18-415;

(b) the assessment for private hospitals in this chapter; or

(c) the intergovernmental transfer in this section.

(3) The intergovernmental transfer is apportioned as follows:

(a) the state teaching hospital is responsible for:

(i) 30% of the portion of the hospital share for the enhancement waiver program; and

(ii) 0% of the portion of the hospital share for the upper payment limit gap; and

(b) non-state government hospitals are responsible for:

(i) 1% of the portion of the hospital share for the enhancement waiver program; and

(ii) 0% of the portion of the hospital share for the upper payment limit gap.

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 11. Section **26-36c-207** is enacted to read:

26-36c-207. Penalties.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this chapter, within the time required by this chapter, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.

(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

(i) any unpaid quarterly assessment or intergovernmental transfer; and

(ii) any unpaid penalty assessment.

(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive or reduce any of the penalties imposed under this chapter.

Section 12. Section **26-36c-208** is enacted to read:

26-36c-208. Primary Care Network Enhancement Fund.

(1) There is created an expendable special revenue fund known as the Primary Care Network Enhancement Fund.

(2) The fund consists of:

(a) assessments and penalties collected under this chapter;

(b) intergovernmental transfers under Section 26-36c-206;

(c) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;

(d) the amount transferred under Subsection 59-14-204(6);

(e) the amount transferred under Subsection 32B-2-301(7);

(f) interest earned on money in the fund; and

(g) additional amounts appropriated by the Legislature.

(3) (a) The fund shall earn interest; and

(b) all interest earned on fund money shall be deposited into the fund.

(4) (a) A state agency administering the provisions of this chapter may use money from the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:

(i) the enhancement waiver program created in Section 26-18-415; and

(ii) the outpatient upper payment limit supplemental payments described in Section 26-36c-210.

(b) No funds described in Subsection (2)(b) may be used to pay the cost of outpatient upper payment limit supplemental payments described in Section 26-36c-210.

(c) Money in the fund may not be used for any purpose not described in this section.

Section 13. Section **26-36c-209** is enacted to read:

26-36c-209. Hospital reimbursement.

(1) If the enhancement waiver program is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include in a contract to provide benefits under the enhancement waiver program a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the enhancement waiver program is implemented by the department as a fee for service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits the department or a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Section 14. Section **26-36c-210** is enacted to read:

26-36c-210. Outpatient upper payment limit supplemental payments.

(1) Beginning on the effective date of the assessment imposed under this chapter, and for each subsequent fiscal year, the department shall implement an outpatient upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection (2).

(2) The allocation of supplemental payment to Utah private hospitals described in Subsection (1):

(a) shall be based on the Medicaid state plan; and

(b) may not exceed the upper payment limit gap.

(3) The department shall use the same outpatient data to allocate the payments under Subsection (2) and to calculate the upper payment limit gap.

(4) The supplemental payments to private hospitals under Subsection (1) are payable for outpatient hospital services provided on or after the later of:

(a) July 1, 2018;

(b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or

(c) the effective date of the coverage provided through the enhancement waiver program.

Section 15. Section **26-36c-211** is enacted to read:

26-36c-211. Repeal of assessment.

(1) The assessment imposed by this chapter shall be repealed when:

(a) the executive director certifies that:

(i) action by Congress is in effect that disqualifies the assessment imposed by this chapter from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(ii) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(A) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(B) creates for any reason a failure of the state to use the assessments for the Medicaid program as described in this chapter; or

(iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; or

(b) this chapter is repealed in accordance with Section 63I-1-226.

(2) If the assessment is repealed under Subsection (1):

(a) the department shall disburse money in the special revenue fund in accordance with the requirements in Subsection 26-36c-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(b) any money remaining in the special revenue fund after the disbursement described in Subsection (2)(a) that was derived from assessments imposed by this chapter shall be refunded to the hospitals in proportion to the amount paid by each hospital; and

(c) any money remaining in the special revenue fund after the disbursements described in Subsections (2)(a) and (b) shall be deposited into the General Fund.

Section 16. Section **32B-2-301** is amended to read:

32B-2-301. State property -- Liquor Control Fund -- Markup Holding Fund.

(1) The following are property of the state:

(a) the money received in the administration of this title, except as otherwise provided; and

(b) property acquired, administered, possessed, or received by the department.

(2) (a) There is created an enterprise fund known as the "Liquor Control Fund."

(b) Except as provided in Sections 32B-3-205 and 32B-2-304, money received in the administration of this title shall be transferred to the Liquor Control Fund.

(3) (a) There is created an enterprise fund known as the "Markup Holding Fund."

(b) In accordance with Section 32B-2-304, the State Tax Commission shall deposit revenue remitted to the State Tax Commission from the markup imposed under Section 32B-2-304 into the Markup Holding Fund.

(c) Money deposited into the Markup Holding Fund may be expended:

(i) to the extent appropriated by the Legislature; and

(ii) to fund the deposits required by Subsection 32B-2-304(4) and Subsection 32B-2-305(4).

(4) The department may draw from the Liquor Control Fund only to the extent appropriated by the Legislature or provided for by statute, except that the department may draw by warrant without an appropriation from the Liquor Control Fund for an expenditure that is directly incurred by the department:

(a) to purchase an alcoholic product;

(b) to transport an alcoholic product from the supplier to a warehouse of the department; and

(c) for variances related to an alcoholic product.

(5) (a) As used in this Subsection (5), "base budget" means the same as that term is defined in legislative rule.

(b) The department's base budget shall include as an appropriation from the Liquor Control Fund:

(i) credit card related fees paid by the department;

(ii) package agency compensation; and

(iii) the department's costs of shipping and warehousing alcoholic products.

(6) Before the transfer required by Subsection (7), the department may retain each fiscal year from the Liquor Control Fund $1,000,000 that the department may use for:

(a) capital equipment purchases;

(b) salary increases for department employees;

(c) performance awards for department employees; or

(d) information technology enhancements because of changes or trends in technology.

(7) [~~The~~] (a) Except as provided in Subsection (7)(b), the department shall transfer annually from the Liquor Control Fund and the State Tax Commission shall transfer annually from the Markup Holding Fund to the General Fund a sum equal to the amount of net profit earned from the sale of liquor since the preceding transfer of money under this Subsection (7). The transfers shall be calculated by no later than September 1 and made by no later than September 30 after a fiscal year. The Division of Finance may make year-end closing entries in the Liquor Control Fund and the Markup Holding Fund in order to comply with Subsection 51-5-6(2).

(b) Subject to Subsection (7)(c), and in accordance with Subsection 26-36c-208(2)(e), for each fiscal year beginning in fiscal year 2019, the department and the State Tax Commission shall transfer to the Primary Care Network Enhancement Fund, created in Section 26-36c-208, any amount described in Subsection (7)(a) in excess of the amount transferred by the department or the State Tax Commission in fiscal year 2018.

(c) The transfer to the Primary Care Network Enhancement Fund, described in Subsection (7)(b), shall be capped at $10,000,000.

(8) (a) By the end of each day, the department shall:

(i) make a deposit to a qualified depository, as defined in Section 51-7-3; and

(ii) report the deposit to the state treasurer.

(b) A commissioner or department employee is not personally liable for a loss caused by the default or failure of a qualified depository.

(c) Money deposited in a qualified depository is entitled to the same priority of payment as other public funds of the state.

(9) If the cash balance of the Liquor Control Fund is not adequate to cover a warrant drawn against the Liquor Control Fund by the department, the cash resources of the General Fund may be used to the extent necessary. At no time may the fund equity of the Liquor Control Fund fall below zero.

Section 17. Section **59-14-204** is amended to read:

59-14-204. Tax basis -- Rate -- Future increase -- Cigarette Tax Restricted Account -- Appropriation and expenditure of revenues.

(1) Except for cigarettes described under Subsection 59-14-210(3), there is levied a tax upon the sale, use, storage, or distribution of cigarettes in the state.

(2) The rates of the tax levied under Subsection (1) are, beginning on July 1, 2010:

(a) 8.5 cents on each cigarette, for all cigarettes weighing not more than three pounds per thousand cigarettes; and

(b) 9.963 cents on each cigarette, for all cigarettes weighing in excess of three pounds per thousand cigarettes.

(3) Except as otherwise provided under this chapter, the tax levied under Subsection (1) shall be paid by any person who is the manufacturer, jobber, importer, distributor, wholesaler, retailer, user, or consumer.

(4) The tax rates specified in this section shall be increased by the commission by the same amount as any future reduction in the federal excise tax on cigarettes.

(5) (a) There is created within the General Fund a restricted account known as the "Cigarette Tax Restricted Account."

(b) The Cigarette Tax Restricted Account consists of:

(i) the first $7,950,000 of the revenues collected from a tax under this section; and

(ii) any other appropriations the Legislature makes to the Cigarette Tax Restricted Account.

(c) For each fiscal year beginning with fiscal year 2011-12 and subject to appropriation by the Legislature, the Division of Finance shall distribute money from the Cigarette Tax Restricted Account as follows:

(i) $250,000 to the Department of Health to be expended for a tobacco prevention and control media campaign targeted towards children;

(ii) $2,900,000 to the Department of Health to be expended for tobacco prevention, reduction, cessation, and control programs;

(iii) $2,000,000 to the University of Utah Health Sciences Center for the Huntsman Cancer Institute to be expended for cancer research; and

(iv) $2,800,000 to the University of Utah Health Sciences Center to be expended for medical education at the University of Utah School of Medicine.

(d) In determining how to appropriate revenue deposited into the Cigarette Tax Restricted Account that is not otherwise appropriated under Subsection (5)(c), the Legislature shall give particular consideration to enhancing Medicaid provider reimbursement rates and medical coverage for the uninsured.

(6) For each fiscal year beginning with fiscal year 2019, the Division of Finance shall distribute to the Primary Care Network Enhancement Fund, created in Section 26-36c-208, any revenues collected from a tax under this section in excess of the revenues collected from a tax under this section in fiscal year 2018.

Section 18. Section **63I-1-226** is amended to read:

63I-1-226. Repeal dates, Title 26.

(1) Section 26-1-40 is repealed July 1, 2019.

(2) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July 1, 2025.

(3) Section 26-10-11 is repealed July 1, 2020.

(4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.

(5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2019.

(6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.

(7) Title 26, Chapter 36c, Primary Care Network Enhancement Hospital Assessment Act, is repealed July 1, 2023.

[~~(7) Section 26-38-2.5 is repealed July 1, 2017.~~]

[~~(8) Section 26-38-2.6 is repealed July 1, 2017.~~]

[~~(9)~~] (8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

Section 19. **Effective date.**

If approved by two-thirds of all the members elected to each house, this bill takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution, Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override.

Legislative Review Note
Office of Legislative Research and General Counsel