

1 HOUSE BILL NO. 505

2 INTRODUCED BY T. WOODS

3

4 A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING REQUIREMENTS FOR INSURANCE COVERAGE
5 OF PRESCRIPTION CONTRACEPTIVES, INCLUDING COVERAGE OF A 12-MONTH SUPPLY OF A
6 CONTRACEPTIVE; AMENDING SECTIONS 2-18-704, 20-25-1403, 33-22-101, 33-31-111, 33-35-306,
7 53-4-1005, AND 53-6-101, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

8

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

10

11 NEW SECTION. **Section 1. Coverage of contraceptives.** (1) Each group or individual disability policy,
12 certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or
13 modified in this state that includes a prescription drug benefit must provide payment, coverage, or reimbursement
14 for prescription contraceptives.

15 (2) Except as provided in subsection (3), the coverage required under this section may be subject to
16 provisions that apply equally to other prescription drugs covered by the policy, certificate, or contract, including
17 but not limited to required copayments, deductibles, and coinsurance.

18 (3) The policy, certificate, or contract must reimburse a health care provider or dispensing entity for
19 dispensing a 12-month supply of a contraceptive at any time during the plan year.

20 (4) A religious employer is exempt from the requirements of this section with respect to a prescription
21 drug benefit that it provides to its employees.

22 (5) For the purposes of this section, the following definitions apply:

23 (a) "Prescription contraceptive" means a drug or device that requires a prescription and is approved by
24 the U.S. Food and Drug Administration to prevent pregnancy.

25 (b) "Religious employer" means an employer:

26 (i) whose purpose is the inculcation of religious values;

27 (ii) that primarily employs persons who share the religious beliefs of the employer;

28 (iii) that primarily serves persons who share the religious beliefs of the employer; and

29 (iv) that is a nonprofit organization under section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.

30

1 **Section 2.** Section 2-18-704, MCA, is amended to read:

2 **"2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain
3 provisions that permit:

4 (a) the member of a group who retires from active service under the appropriate retirement provisions
5 of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19,
6 chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered
7 employment to remain a member of the group until the member becomes eligible for medicare under the federal
8 Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group plan with
9 substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue
10 of that employment, is eligible to participate in another group plan with substantially the same or greater benefits
11 at an equivalent cost;

12 (b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible
13 for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for
14 medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for
15 equivalent insurance coverage as provided in subsection (1)(a);

16 (c) the surviving children of a member to remain members of the group as long as they are eligible for
17 retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage
18 as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving
19 parent or legal guardian.

20 (2) An insurance contract or plan issued under this part must contain the provisions of subsection (1)
21 for remaining a member of the group and also must permit:

22 (a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

23 (b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

24 (c) continued membership in the group by anyone eligible under the provisions of this section,
25 notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

26 (3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a
27 member of the state's group plan until the legislator becomes eligible for medicare under the federal Health
28 Insurance for the Aged Act if the legislator:

29 (i) terminates service in the legislature and is a vested member of a state retirement system provided
30 by law; and

1 (ii) notifies the department of administration in writing within 90 days of the end of the legislator's
2 legislative term.

3 (b) A former legislator may not remain a member of the group plan under the provisions of subsection
4 (3)(a) if the person:

5 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

6 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with
7 substantially the same or greater benefits at an equivalent cost.

8 (c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and
9 subsequently terminates membership may not rejoin the group plan unless the person again serves as a
10 legislator.

11 (4) (a) A state insurance contract or plan must contain provisions that permit continued membership in
12 the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to
13 be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify
14 the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's
15 choice to continue membership in the group plan.

16 (b) A former judge may not remain a member of the group plan under the provisions of this subsection
17 (4) if the person:

18 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

19 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with
20 substantially the same or greater benefits at an equivalent cost; or

21 (iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

22 (c) A judge who remains a member of the group under the provisions of this subsection (4) and
23 subsequently terminates membership may not rejoin the group plan unless the person again serves in a position
24 covered by the state's group plan.

25 (5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the
26 full premium for coverage and for that of the person's covered dependents.

27 (6) An insurance contract or plan issued under this part that provides for the dispensing of prescription
28 drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

29 (a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana
30 that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the

1 same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty
2 to the member; and

3 (b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title
4 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

5 (7) An insurance contract or plan issued under this part must include coverage for:

6 (a) treatment of inborn errors of metabolism, as provided for in 33-22-131; and

7 (b) therapies for Down syndrome, as provided in 33-22-139.

8 (8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in
9 a member's family must provide coverage for well-child care for children from the moment of birth through 7 years
10 of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in
11 the contract or plan.

12 (b) Coverage for well-child care under subsection (8)(a) must include:

13 (i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory
14 tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment
15 services program provided for in 53-6-101; and

16 (ii) routine immunizations according to the schedule for immunization recommended by the immunization
17 practice advisory committee of the U.S. department of health and human services.

18 (c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided
19 at each visit as provided for in this subsection (8).

20 (d) For purposes of this subsection (8):

21 (i) "developmental assessment" and "anticipatory guidance" mean the services described in the
22 Guidelines for Health Supervision II, published by the American academy of pediatrics; and

23 (ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or
24 a health care professional supervised by a physician.

25 (9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a
26 dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the
27 insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued
28 under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance
29 contract or plan, may be required to be paid by the insured and not by the employer.

30 (10) Prior to issuance of an insurance contract or plan under this part, written informational materials

1 describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan
2 member.

3 (11) The state employee group benefit plans and the Montana university system group benefits plans
4 must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician
5 and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient
6 to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment
7 of breast cancer.

8 (12) (a) The state employee group benefit plans and the Montana university system group benefits plans
9 must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any
10 education must be provided by a licensed health care professional with expertise in diabetes.

11 (b) Coverage must include a \$250 benefit for a person each year for medically necessary and prescribed
12 outpatient self-management training and education for the treatment of diabetes.

13 (c) The state employee group benefit plans and the Montana university system group benefits plans must
14 provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids,
15 devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading
16 and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive
17 oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug
18 administration, and glucagon emergency kits.

19 (d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group
20 benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case
21 subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

22 (e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable
23 to all other covered benefits within a given policy.

24 (f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement,
25 accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana
26 university system as benefits to employees, retirees, and their dependents.

27 (13) (a) The state employee group benefit plans and the Montana university system group benefits plans
28 that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as
29 defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall
30 renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer

1 firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the
 2 continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this
 3 section must provide for the same level of benefits as is available to other members of the group. Premiums
 4 charged to a spouse or dependent under this section must be the same as premiums charged to other similarly
 5 situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance
 6 contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured
 7 under a COBRA continuation provision.

8 (b) The state employee group benefit plans and the Montana university system group benefits plans
 9 subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or
 10 dependent only if:

11 (i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms
 12 of the state employee group benefit plans and the Montana university system group benefits plans or if the plans
 13 have not received timely premium payments;

14 (ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an
 15 intentional misrepresentation of a material fact under the terms of the coverage; or

16 (iii) the state employee group benefit plans and the Montana university system group benefits plans are
 17 ceasing to offer coverage in accordance with applicable state law.

18 (14) The state employee group benefit plans and the Montana university system group benefits plans
 19 must comply with the provisions of 33-22-153.

20 (15) An insurance contract or plan issued under this part and the state employee group benefit plans
 21 must comply with the provisions of [section 1]. (See compiler's comments for contingent termination of certain
 22 text.)"
 23

24 **Section 3.** Section 20-25-1403, MCA, is amended to read:

25 **"20-25-1403. (Temporary) Authorization to establish self-insured health plan for students --**
 26 **requirements -- exemption.** (1) The commissioner may establish a self-insured student health plan for enrolled
 27 students of the system and their dependents, including students of a community college district. In developing
 28 a self-insured student health plan, the commissioner shall:

29 (a) maintain the plan on an actuarially sound basis;

30 (b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan;

1 and

2 (c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the
3 plan. The deposits must be expended for claims under the plan and for the costs of administering the plan,
4 including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary
5 reinsurance, and repaying debts.

6 (2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with
7 affected parties, including but not limited to the board of regents and representatives of enrolled students of the
8 system.

9 (3) A self-insured student health plan developed under this part is not responsible for and may not cover
10 any services or pay any expenses for which payment has been made or is due under an automobile, premises,
11 or other private or public medical payment coverage plan or provision or under a workers' compensation plan or
12 program, except when the other payor is required by federal law to be a payor of last resort. The term "services"
13 includes but is not limited to all medical services, procedures, supplies, medications, or other items or services
14 provided to treat an injury or medical condition sustained by a member of the plan.

15 (4) Except for the provisions of Title 33, chapter 40, part 1, the provisions of Title 33 do not apply to the
16 commissioner when exercising the duties provided for in this part. (Terminates December 31, 2017--sec. 14, Ch.
17 363, L. 2013.)

18 **20-25-1403. (Effective January 1, 2018) Authorization to establish self-insured health plan for**
19 **students -- requirements -- exemption.** (1) The commissioner may establish a self-insured student health plan
20 for enrolled students of the system and their dependents, including students of a community college district. In
21 developing a self-insured student health plan, the commissioner shall:

22 (a) maintain the plan on an actuarially sound basis;

23 (b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan;

24 and

25 (c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the
26 plan. The deposits must be expended for claims under the plan and for the costs of administering the plan,
27 including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary
28 reinsurance, and repaying debts.

29 (2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with
30 affected parties, including but not limited to the board of regents and representatives of enrolled students of the

1 system.

2 (3) A self-insured student health plan developed under this part is not responsible for and may not cover
3 any services or pay any expenses for which payment has been made or is due under an automobile, premises,
4 or other private or public medical payment coverage plan or provision or under a workers' compensation plan or
5 program, except when the other payor is required by federal law to be a payor of last resort. The term "services"
6 includes but is not limited to all medical services, procedures, supplies, medications, or other items or services
7 provided to treat an injury or medical condition sustained by a member of the plan.

8 (4) The Except for the provisions of [section 1], the provisions of Title 33 do not apply to the
9 commissioner when exercising the duties provided for in this part."
10

11 **Section 4.** Section 33-22-101, MCA, is amended to read:

12 **"33-22-101. Exceptions to scope.** (1) Subject to subsection (2), parts 1 through 4 of this chapter,
13 except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136,
14 33-22-138, 33-22-140, 33-22-141, 33-22-142, 33-22-153, 33-22-243, and 33-22-304, and part 19 of this chapter
15 do not apply to or affect:

16 (a) any policy of liability or workers' compensation insurance with or without supplementary expense
17 coverage;

18 (b) any group or blanket policy;

19 (c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those
20 provisions relating to disability insurance that:

21 (i) provide additional benefits in case of death or dismemberment or loss of sight by accident or
22 accidental means; or

23 (ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit
24 or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or
25 supplemental contract;

26 (d) reinsurance.

27 (2) Sections 33-22-137, [section 1], 33-22-150 through 33-22-152, and 33-22-301 apply to group or
28 blanket policies."
29

30 **Section 5.** Section 33-31-111, MCA, is amended to read:

1 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided
2 in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization
3 authorized to transact business under this chapter. This provision does not apply to an insurer or health service
4 corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state
5 except with respect to its health maintenance organization activities authorized and regulated pursuant to this
6 chapter.

7 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its
8 representatives is not a violation of any law relating to solicitation or advertising by health professionals.

9 (3) A health maintenance organization authorized under this chapter is not practicing medicine and is
10 exempt from Title 37, chapter 3, relating to the practice of medicine.

11 (4) This chapter does not exempt a health maintenance organization from the applicable certificate of
12 need requirements under Title 50, chapter 5, parts 1 and 3.

13 (5) This section does not exempt a health maintenance organization from the prohibition of pecuniary
14 interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.
15 A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701
16 through 33-3-704.

17 (6) This section does not exempt a health maintenance organization from:

18 (a) prohibitions against interference with certain communications as provided under Title 33, chapter 1,
19 part 8;

20 (b) the provisions of Title 33, chapter 22, part 19;

21 (c) the requirements of 33-22-134 and 33-22-135;

22 (d) network adequacy and quality assurance requirements provided under chapter 36; or

23 (e) the requirements of Title 33, chapter 18, part 9.

24 (7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212,
25 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, section 1,
26 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152,
27 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521,
28 33-22-523, 33-22-524, 33-22-526, 33-22-706, Title 33, chapter 32[, and Title 33, chapter 40, part 1,] apply to
29 health maintenance organizations. (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363,
30 L. 2013.)"

1

2 **Section 6.** Section 33-35-306, MCA, is amended to read:

3 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter,
4 self-funded multiple employer welfare arrangements are subject to the following provisions:

5 (a) 33-1-111;

6 (b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare
7 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

8 (c) Title 33, chapter 1, part 7;

9 (d) 33-3-308;

10 (e) Title 33, chapter 18, except 33-18-242;

11 (f) Title 33, chapter 19;

12 (g) 33-22-107, [section 1], 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141,
13 33-22-142, 33-22-152, and 33-22-153;

14 (h) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; and

15 (i) Title 33, chapter 40, part 1.

16 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
17 employer welfare arrangement that has been issued a certificate of authority that has not been revoked.

18 (Subsection (1)(i) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

19

20 **Section 7.** Section 53-4-1005, MCA, is amended to read:

21 **"53-4-1005. (Temporary) Benefits provided.** (1) Benefits provided to participants in the program may
22 include but are not limited to:

23 (a) inpatient and outpatient hospital services;

24 (b) physician and advanced practice registered nurse services;

25 (c) laboratory and x-ray services;

26 (d) well-child and well-baby services;

27 (e) immunizations;

28 (f) clinic services;

29 (g) dental services;

30 (h) prescription drugs, including coverage of contraceptives in accordance with [section 1];

1 (i) mental health and substance abuse treatment services;

2 (j) hearing and vision exams; and

3 (k) eyeglasses.

4 (2) The program must comply with the provisions of 33-22-153.

5 (3) The department shall adopt rules, pursuant to its authority under 53-4-1009, allowing it to cover
6 significant dental needs beyond those covered in the basic plan. Expenditures under this subsection may not
7 exceed \$100,000 in state funds, plus any matched federal funds, each fiscal year.

8 ~~(4) The department is specifically prohibited from providing payment for birth control contraceptives~~
9 ~~under this program.~~

10 ~~(5)~~(4) The department shall notify enrollees of any restrictions on access to health care providers, of any
11 restrictions on the availability of services by out-of-state providers, and of the methodology for an out-of-state
12 provider to be an eligible provider. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec.
13 3, Ch. 169, L. 2007; sec. 10, Ch. 97, L. 2013.)"

14

15 **Section 8.** Section 53-6-101, MCA, is amended to read:

16 **"53-6-101. Montana medicaid program -- authorization of services.** (1) There is a Montana medicaid
17 program established for the purpose of providing necessary medical services to eligible persons who have need
18 for medical assistance. The Montana medicaid program is a joint federal-state program administered under this
19 chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall
20 administer the Montana medicaid program.

21 (2) The department and the legislature shall consider the following funding principles when considering
22 changes in medicaid policy that either increase or reduce services:

23 (a) protecting those persons who are most vulnerable and most in need, as defined by a combination
24 of economic, social, and medical circumstances;

25 (b) giving preference to the elimination or restoration of an entire medicaid program or service, rather
26 than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

27 (c) giving priority to services that employ the science of prevention to reduce disability and illness,
28 services that treat life-threatening conditions, and services that support independent or assisted living, including
29 pain management, to reduce the need for acute inpatient or residential care.

30 (3) Medical assistance provided by the Montana medicaid program includes the following services:

- 1 (a) inpatient hospital services;
- 2 (b) outpatient hospital services;
- 3 (c) other laboratory and x-ray services, including minimum mammography examination as defined in
4 33-22-132;
- 5 (d) skilled nursing services in long-term care facilities;
- 6 (e) physicians' services;
- 7 (f) nurse specialist services;
- 8 (g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;
- 9 (h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in
10 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;
- 11 (i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant
12 women;
- 13 (j) services that are provided by physician assistants within the scope of their practice and that are
14 otherwise directly reimbursed as allowed under department rule to an existing provider;
- 15 (k) health services provided under a physician's orders by a public health department;
- 16 (l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2); and
- 17 (m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as
18 provided in 33-22-153.
- 19 (4) Medical assistance provided by the Montana medicaid program may, as provided by department rule,
20 also include the following services:
- 21 (a) medical care or any other type of remedial care recognized under state law, furnished by licensed
22 practitioners within the scope of their practice as defined by state law;
- 23 (b) home health care services;
- 24 (c) private-duty nursing services;
- 25 (d) dental services;
- 26 (e) physical therapy services;
- 27 (f) mental health center services administered and funded under a state mental health program
28 authorized under Title 53, chapter 21, part 10;
- 29 (g) clinical social worker services;
- 30 (h) prescribed drugs, dentures, and prosthetic devices; if the program provides coverage of prescription

1 drugs, the coverage must comply with the provisions of [section 1].

2 (i) prescribed eyeglasses;

3 (j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

4 (k) inpatient psychiatric hospital services for persons under 21 years of age;

5 (l) services of professional counselors licensed under Title 37, chapter 23;

6 (m) hospice care, as defined in 42 U.S.C. 1396d(o);

7 (n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case
8 management services for the mentally ill;

9 (o) services of psychologists licensed under Title 37, chapter 17;

10 (p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h),
11 in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

12 (q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

13 (5) Services for persons qualifying for medicaid under the medically needy category of assistance, as
14 described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others
15 qualifying for assistance under the Montana medicaid program. The department is not required to provide all of
16 the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy
17 category of assistance.

18 (6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S.
19 department of health and human services, the department may implement limited medicaid benefits, to be known
20 as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined
21 in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult
22 recipients of medical assistance only who are covered under a group related to a program providing financial
23 assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection
24 (3) but may include those optional services listed in subsections (4)(a) through (4)(q) that the department in its
25 discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds
26 appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the
27 provision of a particular service is commonly covered by private health insurance plans. However, a recipient who
28 is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq.,
29 or is less than 21 years of age is entitled to full medicaid coverage.

30 (7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C.

1 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles,
2 and coinsurance for persons not otherwise eligible for medicaid.

3 (8) The department may set rates for medical and other services provided to recipients of medicaid and
4 may enter into contracts for delivery of services to individual recipients or groups of recipients.

5 (9) The services provided under this part may be only those that are medically necessary and that are
6 the most efficient and cost-effective.

7 (10) The amount, scope, and duration of services provided under this part must be determined by the
8 department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

9 (11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

10 (12) If available funds are not sufficient to provide medical assistance for all eligible persons, the
11 department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical
12 services made available under the Montana medicaid program after taking into consideration the funding
13 principles set forth in subsection (2)."

14
15 **NEW SECTION. Section 9. Codification instruction.** [Section 1] is intended to be codified as an
16 integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

17
18 **NEW SECTION. Section 10. Effective date.** [This act] is effective January 1, 2018.

19 - END -