AN ACT GENERALLY REVISING LAWS RELATED TO FERTILITY PRESERVATION SERVICES FOR PEOPLE DIAGNOSED WITH CANCER; REQUIRING INSURANCE COVERAGE OF FERTILITY PRESERVATION SERVICES; CREATING A VOLUNTARY ASSESSMENT FOR CANCER SCREENING EFFORTS; CREATING A SPECIAL REVENUE ACCOUNT; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-704, 33-31-111, 33-35-306, 53-6-101, AND 61-3-303, MCA; AND PROVIDING EFFECTIVE DATES, AND AN APPLICABILITY DATE.

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

Section 1. Legislative findings -- purpose. (1) The legislature finds that young Montanans who are diagnosed with cancer often learn, shortly before they are to begin the medical treatment needed to save their lives, that the treatment may result in infertility, leaving them only a small window of time in which to decide whether to undergo medically necessary efforts to preserve their ability to have biological families.

(2) The legislature further finds that future fertility is a top quality of life priority for many young cancer patients and that the possibility of infertility may cause significant distress and grief during a time when cancer patients are also facing not only their diagnoses but also the prospects of treatment that may include surgery, chemotherapy, radiation, or a combination of those approaches.

(3) The legislature further finds that fertility preservation is medically necessary and considered part of the standard of care for age-eligible oncology patients.

(4) It is the intent of [sections 1 through 4] to ensure that fertility preservation services for cancer patients are covered by insurance plans in the same manner as other medically necessary care and that cancer patients are made aware of the options for fertility preservation services.

Section 2. Definitions. As used in [sections 1 through 4], the following definitions apply:

(1) "Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

(2) "Medical treatment that may directly or indirectly cause iatrogenic infertility" means treatment with a potential side effect of impaired fertility, as established by a national association for practitioners of reproductive medicine or clinical oncology.

(3) "Standard fertility preservation services" means procedures consistent with established medical practices and professional guidelines published by a national association for practitioners of reproductive medicine or clinical oncology.

Section 3. Coverage of fertility preservation services. (1) Each individual and group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state that provides coverage for hospital, medical, or surgical services must cover medically necessary costs for standard fertility preservation services when an insured member is diagnosed with cancer and the standard of care involves medical treatment that may directly or indirectly cause iatrogenic infertility.

(2) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other hospital, medical, or surgical services covered under the plan may not be imposed on coverage for fertility preservation services.

(3) This section does not apply to disability income, hospital indemnity, accident-only, vision, dental, or long-term care policies.

Section 4. Cancer screening account. (1) There is a cancer screening account in the state special revenue fund established in 17-2-102 to the credit of the department of public health and human services.

(2) The account consists of:

(a) money collected from the donation provided for in 61-3-303(6)(d);

(b) other gifts and donations to the department for cancer screening efforts; and

(c) interest and income earned on the account.

(3) Money in the account must be used by the department of public health and human services to support cancer screening efforts.

Section 5. Section 2-18-704, MCA, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a

position covered by the state's group plan.

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

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

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

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

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

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

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

(c) treatment for children with hearing loss as provided in 33-22-128(1) and (2);

(d) fertility preservation services as required under [section 3];

~~(d)~~(e) the care and treatment of mental illness in accordance with the provisions of Title 33, chapter 22, part 7; and

~~(e)~~(f) telehealth services, as provided for in 33-22-138.

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

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

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

(ii) routine immunizations according to the schedule for immunization recommended by the

advisory committee on immunization practices of the U.S. department of health and human services.

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

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

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

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

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

(10) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.

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

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

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

(c) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes,

injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

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

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

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

(13) (a) The state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as is available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

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

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if

the plans have not received timely premium payments;

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

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

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

(15) An insurance contract or plan issued under this part and a group benefits plan issued by the Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter 22, part 7. (See compiler's comments for contingent termination of certain text.)"

Section 6. Section 33-31-111, MCA, is amended to read:

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

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

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

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

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

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

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

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

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

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

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

(7) Other chapters and provisions of this title apply to health maintenance organizations as follows: Title 33, chapter 1, parts 6, 12, and 13; 33-2-1114; 33-2-1211 and 33-2-1212; Title 33, chapter 2, parts 13, 19, 23, and 24; 33-3-401; 33-3-422; 33-3-431; Title 33, chapter 3, part 6; Title 33, chapter 10; Title 33, chapter 12; 33-15-308; Title 33, chapter 17; Title 33, chapter 19; 33-22-107; 33-22-128; 33-22-129; 33-22-131; 33-22-136 through 33-22-139; 33-22-141 and 33-22-142; 33-22-152 and 33-22-153; [section 3]; 33-22-156 through 33-22-159; 33-22-180; 33-22-244; 33-22-246 and 33-22-247; 33-22-514 and 33-22-515; 33-22-521; 33-22-523 and 33-22-524; 33-22-526; and Title 33, chapter 32."

Section 7. Section 33-35-306, MCA, is amended to read:

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

(a) 33-1-111;

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

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

(d) Title 33, chapter 2, parts 23 and 24;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-128, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141,

33-22-142, 33-22-152, and 33-22-153;

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

(k) Title 33, chapter 22, part 7, and [sections 1 through 4]; and

(l) 33-22-707.

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

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

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

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

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

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

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

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

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined

in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age, in accordance with federal regulations and subsection (10)(b);

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department;

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2);

(m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as provided in 33-22-153;

(n) for children 18 years of age and younger, habilitative services as defined in 53-4-1103; ~~and~~

(o) services provided by a person certified in accordance with 37-2-318 to provide services in accordance with the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.; and

(p) fertility preservation services in accordance with [section 3].

(4) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

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

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

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

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

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

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

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

(q) services of behavioral health peer support specialists certified under Title 37, chapter 38, provided to adults 18 years of age and older with a diagnosis of a mental disorder, as defined in 53-21-102; and

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

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

(6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving cash assistance, as defined in 53-4-201, as the specified caretaker relative of a dependent child and for all adult recipients of medical assistance only who are covered under a group related to a program providing cash assistance, as

defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection (3) but may include those optional services listed in subsections (4)(a) through (4)(r) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, 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.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

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

(b) The department shall strive to close gaps in services provided to individuals suffering from mental illness and co-occurring disorders by doing the following:

(i) simplifying administrative rules, payment methods, and contracting processes for providing services to individuals of different ages, diagnoses, and treatments. Any adjustments to payments must be cost-neutral for the biennium beginning July 1, 2017.

(ii) publishing a report on an annual basis that describes the process that a mental health center or chemical dependency facility, as those terms are defined in 50-5-101, must utilize in order to receive payment from Montana medicaid for services provided to individuals of different ages, diagnoses, and treatments.

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

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

(b) The department shall, with reasonable promptness, provide access to all medically necessary services prescribed under the early and periodic screening, diagnosis, and treatment benefit, including access to prescription drugs and durable medical equipment for which the department has not negotiated a rebate.

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

(12) (a) Prior to enacting changes to provider rates, medicaid waivers, or the medicaid state plan, the department of public health and human services shall report this information to the following committees:

(i) the children, families, health, and human services interim committee;

(ii) the legislative finance committee; and

(iii) the health and human services budget committee.

(b) In its report to the committees, the department shall provide an explanation for the proposed changes and an estimated budget impact to the department over the next 4 fiscal years.

(13) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2). (Subsection (3)(o) terminates September 30, 2023--sec. 7, Ch. 412, L. 2019.)"

Section 9. Section 61-3-303, MCA, is amended to read:

"**61-3-303. Original registration -- process -- fees.** (1) Except as provided in 61-3-324, a Montana resident who is an owner of a motor vehicle, trailer, semitrailer, or pole trailer operated or driven upon the public highways of this state shall register the motor vehicle, trailer, semitrailer, or pole trailer in the county where the registering owner is domiciled. A nonresident who has an interest in real property in Montana may register in the county where the real property is located a motor vehicle, trailer, semitrailer, or pole trailer operated or driven upon the public highways of this state.

(2) A Montana resident who is an owner of a motor vehicle, trailer, semitrailer, or pole trailer with co-owners, one or more of whom are not Montana residents, may register the vehicle regardless of the fact that one or more of the co-owners would otherwise not qualify to register the vehicle under subsection (1) if the registering Montana resident is:

(a) an individual human being; and

(b) the principal operator of, and in whom is vested the right of possession and control of, the vehicle.

(3) Except as provided in subsection (4), the county treasurer or an authorized agent shall register any vehicle for which:

(a) as of the date that the motor vehicle, trailer, semitrailer, or pole trailer is to be registered, an owner delivers an application for a certificate of title to the department, an authorized agent, or a county treasurer; or

(b) the county treasurer or an authorized agent confirms that the department has an electronic record of title for the motor vehicle, trailer, semitrailer, or pole trailer as provided under 61-3-101.

(4) (a) A county treasurer or an authorized agent may register a motor vehicle, trailer, semitrailer, or pole trailer for which a certificate of title and registration were issued in another jurisdiction and for which registration is required under 61-3-701 after the county treasurer or the authorized agent examines the current out-of-jurisdiction registration certificate or receipt and receives payment of the fees required in 61-3-701. The county treasurer or an authorized agent may ask the motor vehicle, trailer, semitrailer, or pole trailer owner to provide additional information, prescribed by the department, to ensure that the electronic record of registration maintained by the department is complete.

(b) A county treasurer or an authorized agent shall collect fees pursuant to 61-3-203 and 61-3-220(4) and issue a 90-day temporary registration permit pursuant to 61-3-224 for a motor vehicle, trailer, semitrailer, pole trailer, motorboat, sailboat that is 12 feet in length or longer, snowmobile, or off-highway vehicle for which the new owner cannot, due to circumstances beyond the new owner's control, surrender a previously assigned certificate of title. The new owner shall request the 90-day temporary registration permit from the authorized agent or county treasurer that originally issued the temporary registration permit.

(5) Upon registering a motor vehicle, trailer, semitrailer, or pole trailer for the first time in this state, the county treasurer or an authorized agent shall:

(a) update the electronic record of title, if any, maintained for the vehicle by the department under 61-3-101;

(b) assign a registration period for the vehicle under 61-3-311;

(c) determine the vehicle's age, if required, under 61-3-501;

(d) determine the amount of fees, including local option taxes or fees, to be paid under subsection (6); and

(e) assign and issue license plates for the vehicle under 61-3-331.

(6) Unless otherwise provided by law, a person registering a motor vehicle shall pay to the county treasurer or an authorized agent:

(a) the fees in lieu of tax or registration fees as required for:

(i) a light vehicle under 61-3-321 or 61-3-562, in addition to, if applicable, any local option tax or fee under 61-3-537 or 61-3-570;

(ii) a motor home under 61-3-321;

(iii) a travel trailer under 61-3-321;

(iv) a motorcycle or quadricycle under 61-3-321;

(v) a bus, a truck having a manufacturer's rated capacity of more than 1 ton, or a truck tractor under 61-3-321 and 61-3-529; or

(vi) a trailer under 61-3-321;

(b) a donation of $1 or more if the person indicates that the person wishes to donate to promote awareness and education efforts for procurement of organ and tissue donations in Montana to favorably impact anatomical gifts; ~~and~~

(c) a donation of $1 or more if the person indicates that the person wishes to donate to promote education on, support for, and awareness of traumatic brain injury; and

(d) a donation of $1 or more if the person indicates that the person wishes to donate to a program supporting cancer screening.

(7) The county treasurer or an authorized agent may not issue a registration receipt or license plates for the motor vehicle, trailer, semitrailer, or pole trailer to the owner unless the owner makes the payments required by subsection (6).

(8) The department may make full and complete investigation of the registration status of the motor vehicle, trailer, semitrailer, or pole trailer. A person seeking to register a motor vehicle, trailer, semitrailer, or pole trailer under this section shall provide additional information to support the registration to the department if requested.

(9) Revenue that accrues from the voluntary ~~donation~~ donations provided for in subsection (6)~~(b)~~ must be forwarded by the respective county treasurer or an authorized agent to the department for deposit as

follows:

(a) in the state special revenue fund to the credit of an account established by the department of labor and industry to support activities related to awareness and education efforts for procurement of organ and tissue donations for anatomical gifts if the revenue is from the donation provided for in subsection (6)(b);

(b) to the credit of the account established in 2-15-2218 if the revenue is from the donation provided for in subsection (6)(c); and

(c) to the credit of the special revenue account established in [section 4] if the revenue is from the donation provided for in subsection (6)(d).

(10) (a) Except as provided in subsection (10)(b), the fees in lieu of tax, taxes, and fees imposed on or collected from the registration of a travel trailer, motorcycle, or quadricycle or a trailer, semitrailer, or pole trailer that has a declared weight of less than 26,000 pounds are required to be paid only once during the time that the travel trailer, motorcycle, quadricycle, trailer, semitrailer, or pole trailer is owned by the same person who registered the travel trailer, motorcycle, quadricycle, trailer, semitrailer, or pole trailer. When registered, a travel trailer, motorcycle, quadricycle, trailer, semitrailer, or pole trailer is registered permanently unless ownership is transferred or unless it was registered under 61-3-701.

(b) Whenever ownership of a travel trailer, motorcycle, quadricycle, trailer, semitrailer, or pole trailer is transferred, the new owner is required to register the travel trailer, motorcycle, quadricycle, trailer, semitrailer, or pole trailer as if it were being registered for the first time, including paying all of the required fees in lieu of tax, taxes, and fees.

~~(11) Revenue that accrues from the voluntary donation provided in subsection (6)(c) must be forwarded by the respective county treasurer or an authorized agent to the department for deposit in the state special revenue fund to the credit of the account established in 2-15-2218 to support activities related to education regarding prevention of traumatic brain injury.~~

~~(12)~~(11) The department, an authorized agent of the department, or a county treasurer shall use the online motor vehicle liability insurance verification system provided in 61-6-157 to verify that the vehicle owner has complied with the requirements of 61-6-301."

Section 10. Codification instruction. [Sections 1 through 4] are intended to be codified as a new

part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 4].

Section 11. Effective dates. (1) Except as provided in subsection (2), [this act] is effective January 1, 2024.

(2) [Sections 4 and 9] and this section are effective July 1, 2023.

Section 12. Applicability. [This act] applies to insurance policies, certificates, and contracts issued or renewed on or after January 1, 2024.

- END -

I hereby certify that the within bill,

SB 516, originated in the Senate.

_____

Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2023.

_____

Speaker of the House

Signed this _____day

of_____, 2023.

SENATE BILL NO. 516

INTRODUCED BY J. GROSS, F. SMITH, D. SALOMON, S. FITZPATRICK, E. MCCLAFFERTY, J. WELBORN, B. MOLNAR, M. LANG, D. ZOLNIKOV, R. LYNCH, A. OLSEN, W. CURDY, M. DUNWELL, J. ELLIS, D. HAYMAN, C. POPE, S. WEBBER, D. LOGE, R. FITZGERALD, B. USHER, E. BOLDMAN, S. MORIGEAU, J. SMALL, L. BISHOP, J. ELLSWORTH, D. HARVEY, K. BOGNER, B. GILLESPIE, J. KASSMIER, P. FLOWERS, M. FOX, L. BREWSTER, A. BUCKLEY, M. THANE, C. FRIEDEL, S. O'BRIEN, G. PARRY, L. SMITH, M. CUFFE, G. HERTZ, D. LENZ, W. SALES, T. VERMEIRE

AN ACT GENERALLY REVISING LAWS RELATED TO FERTILITY PRESERVATION SERVICES FOR PEOPLE DIAGNOSED WITH CANCER; REQUIRING INSURANCE COVERAGE OF FERTILITY PRESERVATION SERVICES; CREATING A VOLUNTARY ASSESSMENT FOR CANCER SCREENING EFFORTS; CREATING A SPECIAL REVENUE ACCOUNT; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-704, 33-31-111, 33-35-306, 53-6-101, AND 61-3-303, MCA; AND PROVIDING EFFECTIVE DATES, AND AN APPLICABILITY DATE.