_____ BILL NO. _____

INTRODUCED BY _____

BY REQUEST OF THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

A BILL FOR AN ACT ENTITLED: “AN ACT REVISING HEALTHY MONTANA KIDS AND THE MONTANA CHILDREN'S HEALTH INSURANCE PROGRAM; UPDATING QUALIFICATION CRITERIA; REVISING DEFINITIONS; AND AMENDING SECTIONS 53-4-1003, 53-4-1004, 53-4-1005, 53-4-1103, AND 53-4-1105, MCA.”

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

Section 1. Section 53-4-1003, MCA, is amended to read:

"**53-4-1003. (Temporary) Establishment and administration of program.** The department of public health and human services may establish, administer, and monitor a program to provide health care to uninsured children. ~~The~~ Except as provided in 53-4-1115, the department may not use money appropriated for this program to expand eligibility criteria for the Montana medicaid program. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 2. Section 53-4-1004, MCA, is amended to read:

"**53-4-1004. (Temporary) Eligibility for program -- rulemaking.** (1) To be considered eligible for the program, a child:

(a) must be 18 years of age or younger;

(b) must have a combined family income at or below ~~250%~~ 261% of the federal poverty level or at a lower level determined by the department of public health and human services as provided in subsection (4);

(c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c)~~, for 3 months prior to enrollment in the program or since birth, whichever period is less~~;

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate or may limit the amount, scope, or duration of specific services provided. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 14, I.M. No. 155, approved November 4, 2008.)"

Section 3. Section 53-4-1005, MCA, is amended to read:

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

(a) inpatient and outpatient hospital services;

(b) physician, physician assistant, and advanced practice registered nurse services;

(c) laboratory and x-ray services;

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

(e) immunizations;

(f) clinic services;

(g) dental services;

(h) prescription drugs;

(i) mental health and substance abuse treatment services;

(j) habilitative services as defined in 53-4-1103;

(k) hearing and vision exams; and

(l) eyeglasses.

(2) The program must comply with the provisions of 33-22-153 and 53-6-197.

~~(3) The department shall adopt rules, pursuant to its authority under 53-4-1009, allowing it to cover~~

~~significant dental needs beyond those covered in the basic plan. Expenditures under this subsection may not exceed $100,000 in state funds, plus any matched federal funds, each fiscal year.~~

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

~~(5)~~ (3) The department shall notify enrollees of any restrictions on access to health care providers, of any restrictions on the availability of services by out-of-state providers, and of the methodology for an out-of-state provider to be an eligible provider.

~~(6)~~ (4) (a) If benefits provided under the program include gender transition treatment or subsequent treatment directly related to the provision of gender transition treatment, benefits provided under the program must also include detransition treatment under equivalent cost-sharing policies.

(b) If benefits provided under the program cease to include gender transition treatment, the program is not required to provide equivalent coverage for detransition treatment, except that the program must provide equivalent coverage to participants who were enrolled when gender transition treatment was provided and received benefits under that coverage.

(c) For the purposes of this subsection ~~(6)~~ (4), "gender transition treatment" means the following medical treatments provided:

(i) to a female to address her perception that her gender or sex is not female:

(A) surgical procedures, including a vaginectomy, hysterectomy, oophorectomy, ovariectomy, reconstruction of the urethra, metoidioplasty, phalloplasty, scrotoplasty, implantation of erection or testicular protheses, subcutaneous mastectomy, voice surgery, and pectoral implants;

(B) supraphysiologic doses of testosterone or other androgens; or

(C) puberty blockers, such as GnRH agonists or other synthetic drugs that suppress the production of estrogen and progesterone to delay or suppress pubertal development in female minors; and

(ii) to a male to address his perception that his gender or sex is not male:

(A) surgical procedures, including a penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, augmentation mammoplasty, facial feminization surgery, voice surgery, thyroid cartilage reduction, and gluteal augmentation;

(B) supraphysiologic doses of estrogen; or

(C) puberty blockers, such as GnRH agonists or other synthetic drugs that suppress the production of testosterone to delay or suppress pubertal development in male minors. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999, sec. 3, Ch. 169, L. 2007, sec. 10, Ch. 97, L. 2013, sec. 5, Ch. 399, L. 2017.)"

Section 4. Section 53-4-1103, MCA, is amended to read:

"**53-4-1103. Definitions.** For the purposes of part 10 and this part, the following definitions apply:

(1) "Comprehensive" means health insurance having benefits at least as extensive as those provided under the children's health insurance program.

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

(3) "Enrollee" means a child who is enrolled or in the process of being enrolled in the plan, including children already enrolled in the programs described in 53-4-1104(2).

~~(4) (a) "Enrollment partner " means an organization or individual approved by the department to assist in enrolling eligible children in the plan.~~

~~(b) An enrollment partner may be but is not limited to:~~

~~(i) a licensed health care provider;~~

~~(ii) a school;~~

~~(iii) a community-based organization; or~~

~~(iv) a government agency.~~

~~(5)~~ (4) "Habilitative services" means services to help a child maintain, learn, or improve skills and functioning for daily living or to prevent deterioration of skills and that may be offered in a variety of settings. The services include but are not limited to:

(a) physical therapy;

(b) occupational therapy;

(c) speech-language pathology; and

(d) behavioral health treatment, including applied behavior analysis provided by a board-certified behavior analyst.

~~(6)~~ (5) "Health coverage" means a program administered by the department or a disability insurance plan, referred to in 33-1-207(1)(b), that provides public or private health insurance for children.

~~(7)~~ (6) "Income" has the meaning provided in 15-30-2337(9)(a).

~~(8)~~ (7) "Plan" means the healthy Montana kids plan established in 53-4-1104.

~~(9)~~ (8) "Premium" means the amount of money charged to provide coverage under a public or private health coverage plan.

~~(10)~~ (9) "Presumptive eligibility" has the meaning provided in 42 CFR 457.355.

(10) (a) "Qualified entity" means an organization or individual approved by the department to assist in enrolling eligible children in the plan.

(b) A qualified entity may be but is not limited to:

(i) a licensed health care provider;

(ii) a school;

(iii) a community-based organization; or

(iv) a government agency."

Section 5. Section 53-4-1105, MCA, is amended to read:

"**53-4-1105. Rulemaking -- active enrollment -- plan coordination.** (1) The department shall adopt rules necessary to implement this part, including plan administration, plan enrollment, outreach efforts, and standards of performance to allow ~~enrollment partners~~ qualified entities to assist in enrolling children in the plan or other health coverage plans administered by the department.

(2) The rules must:

(a) establish a process for identifying and approving ~~enrollment partners~~ qualified entities;

(b) create and define an active enrollment process;

(c) promote seamless movement between programs described in 53-4-1104(2);

(d) promote accessible enrollment through ~~enrollment partners~~ qualified entities;

(e) provide, to the extent permitted by law, a single point of access in the department for plan members;

(f) define income for purposes of determining eligibility for children's health coverage programs

within the plan;

(g) provide for presumptive eligibility; and

(h) encourage ~~enrollment partners~~ qualified entities to actively enroll as many eligible, uninsured children as possible in the plan or in an employer-sponsored plan as described in 53-4-1108.

(3) The rules may include the development of ~~enrollment partner~~ qualified entity training, technical assistance programs, and performance measures.

(4) The rules may provide for an exemption from the active enrollment process based upon an individual showing of:

(a) religious conviction;

(b) private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), obtained by the parents for the child from a private group or individual health insurance issuer or under a self-funded employer health plan; or

(c) other compelling circumstances.

(5) The rules governing eligibility and premium assistance must be consistent with this part. Rules may include but are not limited to financial standards and criteria for income, nonfinancial criteria, family responsibility, residency, the application process, termination of eligibility, definition of terms, and confidentiality of applicant and recipient information."

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