AN ACT GENERALLY REVISING LAWS RELATED TO GENDER TRANSITION TREATMENT; PROVIDING A STATUTE OF LIMITATIONS FOR TORT ACTIONS INVOLVING GENDER TRANSITION TREATMENT ON MINORS; PROVIDING FOR RECIPROCAL COVERAGE OF DETRANSITION TREATMENT IN PRIVATE INSURANCE AND PUBLIC EMPLOYEE AND MONTANA UNIVERSITY SYSTEM INSURANCE PLANS; PROVIDING THAT DETRANSITION TREATMENT BE INCLUDED AS A SERVICE UNDER MEDICAID AND HEALTHY MONTANA KIDS IN CERTAIN SITUATIONS; AMENDING SECTIONS 2-18-704, 27-2-204, 27-2-205, 33-31-111, 33-35-306, 53-4-1005, AND 53-6-101, MCA; AND PROVIDING ~~A DELAYED EFFECTIVE DATE~~ EFFECTIVE DATES~~, A RETROACTIVE APPLICABILITY DATE, AND AN APPLICABILITY DATE~~.~~"~~

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

**Section 1. Tort actions -- gender transition treatment for minors.** (1) An action brought by a person for damages for injuries suffered from gender transition treatment the person received as a minor must be commenced ~~within 25years from~~ by the date the person reaches ~~18~~ 25 years of age or within ~~4~~ 2 years from the time of discovery by the person of both the injury and the causal relationship between the gender transition treatment and the injury, whichever occurs later, except that an action may not be commenced after the person reaches 30 years of age.

(2) For the purposes of this section, "gender transition treatment" means the following medical treatments provided:

(a) to a female minor to address the minor's perception that her gender or sex is not female:

(i) 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;

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

(iii) 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

(b) to a male minor to address the minor's perception that his gender or sex is not male:

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

(ii) supraphysiologic doses of estrogen; or

(iii) 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.

**Section 2. Reciprocity in gender transition treatment coverage required.** (1) A group or individual insurance policy that includes coverage for gender transition treatment or subsequent treatment directly related to the provision of gender transition treatment must also include coverage for detransition treatment under equivalent cost-sharing policies.

(2) If the group or individual insurance policy ceases coverage for gender transition treatment, the policy is not required to provide equivalent coverage for detransition treatment, except that the policy must provide equivalent coverage to insureds who were enrolled when gender transition treatment coverage was provided and received benefits under that coverage.

(3) For the purposes of this section "gender transition treatment" means the following medical treatments provided:

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

(i) 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;

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

(iii) 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

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

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

(ii) supraphysiologic doses of estrogen; or

(iii) 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.

**Section 3.** 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 33-22-2103;

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

(f) telehealth services, as provided for in 33-22-138; and

(g) refills of prescription eyedrops as provided in 33-22-154.

(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) (i) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for medically necessary and prescribed 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. At a minimum, the benefit must consist of:

(A) 20 visits of training and education in diabetes self-management provided in either an individual or group setting if the person has not received the training and education previously; and

(B) 12 visits of followup diabetes self-management training and education services in subsequent years for an insured who has previously received and exhausted the initial 20 visits of education.

(ii) For the purposes of this subsection (12)(a), the term "visit" refers to a period of 30 minutes.

(b) 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.

(c) Nothing in subsection (12)(a) or (12)(b) 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) or (12)(b), as appropriate, does not apply.

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

(e) 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) Except as provided in subsection (16), 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.

(16) The employing state agency of a law enforcement officer as defined in 2-15-2040 who is covered under the state employee group benefit plan shall:

(a) if the officer is catastrophically injured in the line of duty as defined in 2-15-2040, enroll the officer and the officer's covered spouse or dependent children in COBRA continuation coverage when that officer is terminated from employment as a result of the catastrophic injury. The officer and the officer's spouse or dependent children may opt out of COBRA continuation coverage within 60 days of enrollment.

(b) enroll the officer's covered spouse or dependent children in COBRA continuation coverage if the officer dies in the line of duty as defined in 2-15-2040. The officer's spouse or dependent children may opt out of COBRA coverage within 60 days of the date of enrollment.

(c) pay the COBRA premium for 4 months of COBRA continuation coverage for the officer and the officer's covered spouse or dependent children enrolled in COBRA continuation coverage pursuant to subsections (16)(a) or (16)(b), after which time the officer and the officer's spouse or dependent children shall pay the COBRA premium.

(17) (a) An insurance contract or plan issued under this part or a group benefits plan issued by the Montana university system that includes coverage for gender transition treatment or subsequent treatment directly related to the provision of gender transition treatment must also include coverage for detransition treatment under equivalent cost-sharing policies.

(b) If an insurance contract or plan issued under this part or a group benefits plan issued by the Montana university system ceases coverage for gender transition treatment, the plan is not required to provide equivalent coverage for detransition treatment, except that the plan must provide equivalent coverage to insureds who were enrolled when gender transition treatment coverage was provided and received benefits under that coverage.

(c) For the purposes of this subsection (17), "gender transition treatment" means the following medical treatments provided:

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

(i) 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;

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

(iii) 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

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

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

(ii) supraphysiologic doses of estrogen; or

(iii) 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. (See compiler's comments for contingent termination of certain text.)"

**Section 4.** Section 27-2-204, MCA, is amended to read:

"**27-2-204. Tort actions -- general and personal injury.** (1) Except as provided in 27-2-216 and [section 1], the period prescribed for the commencement of an action ~~upon~~ on a liability not founded ~~upon~~ on an instrument in writing is within 3 years.

(2) The period prescribed for the commencement of an action to recover damages for the death of one caused by the wrongful act or neglect of another is within 3 years, except when the wrongful death is the result of a homicide, in which case the period is within 10 years.

(3) The period prescribed for the commencement of an action for libel, slander, assault, battery, false imprisonment, or seduction is within 2 years."

**Section 5.** Section 27-2-205, MCA, is amended to read:

"**27-2-205. Actions for medical malpractice.** (1) ~~Action~~ Except as provided in [section 1], action in tort or contract for injury or death against a physician or surgeon, physician assistant, dentist, dental hygienist, registered nurse, advanced practice registered nurse, nursing home or hospital administrator, dispensing optician, optometrist, licensed physical therapist, podiatrist, psychologist, osteopath, chiropractor, clinical laboratory bioanalyst, clinical laboratory technologist, pharmacist, veterinarian, a licensed hospital or long-term care facility, or licensed medical professional corporation, based ~~upon~~ on alleged professional negligence or for rendering professional services without consent or for an act, error, or omission, must, except as provided in subsection (2), be commenced within 2 years after the date of injury or within 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of injury. However, this time limitation is tolled for any period during which there has been a failure to disclose any act, error, or omission ~~upon~~ on which an action is based and that is known to the defendant or through the use of reasonable diligence subsequent to the act, error, or omission would have been known to the defendant.

(2) Notwithstanding the provisions of 27-2-401, in an action for death or injury of a minor who was

under the age of 4 on the date of the minor's injury, the period of limitations in subsection (1) begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first, and the time for commencement of the action is tolled during any period during which the minor does not reside with a parent or guardian."

**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; 33-22-114; 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 through 33-22-159; 33-22-180; [section 2]; 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; 33-22-2103; 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, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, [section 2], and 33-22-152 through 33-22-155;

(j) 33-22-316;

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

(l) Title 33, chapter 22, parts 7 and 21; and

(m) 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 53-4-1005, 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) 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) 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), "gender transition treatment" means the following medical treatments provided:

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

(i) 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;

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

(iii) 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

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

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

(ii) supraphysiologic doses of estrogen; or

(iii) 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 9.** 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;

(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.;

(p) fertility preservation services in accordance with 33-22-2103; and

(q) planned home births for women with a low risk of adverse birth outcomes, as established by the appropriate licensing board, that are attended by certified nurse-midwives licensed under Title 37, chapter 8, or direct-entry midwives licensed under Title 37, chapter 27. Coverage under this section includes prenatal care and postpartum care.

(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[, including services provided by pediatric complex care assistants licensed pursuant to 37-2-603];

(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 clinical professional counselors licensed under Title 37, chapter 39;

(m) services of a marriage and family therapist licensed under Title 37, chapter 39;

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

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

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

(q) 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;

(r) services of behavioral health peer support specialists certified under Title 37, chapter 39, provided to adults 18 years of age and older with a diagnosis of a mental disorder, as defined in 53-21-102; and

(s) 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)(s) 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 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).

(14) If services provided under the Montana medicaid program include gender transition treatment or subsequent treatment directly related to the provision of gender transition treatment, services provided under the program must also include detransition treatment under equivalent cost-sharing policies.

(b) If services 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 recipients who were enrolled when gender transition treatment was provided and received benefits under that coverage.

(c) For the purposes of this subsection (14), "gender transition treatment" means the following medical treatments provided:

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

(i) 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;

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

(iii) 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

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

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

(ii) supraphysiologic doses of estrogen; or

(iii) 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. (Subsection (3)(o) terminates September 30, 2025--sec. 1, Ch. 298, L. 2023; bracketed language in subsection (4)(b) terminates June 30, 2031--sec. 10, Ch. 628, L. 2023.)"

**Section 10. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 27, chapter 2, part 2, and the provisions of Title 27, chapter 2, part 2, apply to [section 1].

(2) [Section 2] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 2].

**Section 11. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective October 1, 2026.

(2) [Section 12] and this section are effective on passage and approval.

**Section 12. Coordination instruction.** If both Senate Bill No. 218 and [this act] are passed and approved, then [section 1 of this act] must be amended to include a new subsection (2) that reads as follows:

"(2) An action brought pursuant to [section 1 of Senate Bill No. 218] for injuries suffered from gender transition treatment the person received as a minor must be brought within the timeframes specified in this section."

**Section 13. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

- END -

I hereby certify that the within bill,

HB 682, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2025.

_____

President of the Senate

Signed this _____day

of_____, 2025.

HOUSE BILL NO. 682

INTRODUCED BY G. KMETZ, V. RICCI, L. SCHUBERT, S. KLAKKEN, T. SHARP, R. GREGG, T. MANZELLA, D. EMRICH, S. GIST, C. HINKLE, B. LER, J. SCHILLINGER, B. MITCHELL, K. SEEKINS-CROWE, S. MANESS, J. HINKLE

AN ACT GENERALLY REVISING LAWS RELATED TO GENDER TRANSITION TREATMENT; PROVIDING A STATUTE OF LIMITATIONS FOR TORT ACTIONS INVOLVING GENDER TRANSITION TREATMENT ON MINORS; PROVIDING FOR RECIPROCAL COVERAGE OF DETRANSITION TREATMENT IN PRIVATE INSURANCE AND PUBLIC EMPLOYEE AND MONTANA UNIVERSITY SYSTEM INSURANCE PLANS; PROVIDING THAT DETRANSITION TREATMENT BE INCLUDED AS A SERVICE UNDER MEDICAID AND HEALTHY MONTANA KIDS IN CERTAIN SITUATIONS; AMENDING SECTIONS 2-18-704, 27-2-204, 27-2-205, 33-31-111, 33-35-306, 53-4-1005, AND 53-6-101, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE EFFECTIVE DATES, A RETROACTIVE APPLICABILITY DATE, AND AN APPLICABILITY DATE."