

1 \_\_\_\_\_ BILL NO. \_\_\_\_\_

2 INTRODUCED BY \_\_\_\_\_  
3 (Primary Sponsor)

4 A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING REQUIREMENTS ON INSURANCE COVERAGE  
5 OF CONTINUOUS GLUCOSE MONITORS AND SUPPLIES; PROVIDING AN APPROPRIATION; AMENDING  
6 SECTIONS 2-18-704 AND 33-22-129, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN  
7 APPLICABILITY DATE."

8  
9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

10  
11 **NEW SECTION. Section 1. Coverage of glucose monitoring supplies.** (1) Each individual  
12 disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery,  
13 renewed, extended, or modified in this state must provide coverage of continuous glucose monitors and monitor  
14 supplies if a person is diagnosed with type I or type II diabetes and a monitor is determined medically  
15 necessary by the individual's health care provider and prescribed by the health care provider acting within the  
16 scope of the provider's license. A policy, certificate, or contract may not contain coverage based on the stage of  
17 the insured's disease of diabetes or the insured's diagnosed need for insulin.

18 (2) Coverage under this section may be subject to deductibles, coinsurance, and copayment  
19 provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to  
20 other medical services covered under the plan may not be imposed on coverage of a continuous glucose  
21 monitor.

22 (3) This section does not apply to disability income, hospital indemnity, medicare supplement,  
23 specified disease, or long-term care policies.

24

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

26 **"2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must  
27 contain provisions that permit:

28 (a) the member of a group who retires from active service under the appropriate retirement

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

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

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

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

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

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

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

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

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

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

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

- 3 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or  
4 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan  
5 with substantially the same or greater benefits at an equivalent cost.

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

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

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

- 16 (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;  
17 (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan  
18 with substantially the same or greater benefits at an equivalent cost; or  
19 (iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

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

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

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

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

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

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

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

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

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

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

9 (d) fertility preservation services as required under 33-22-2103;

10 (e) the care and treatment of mental illness in accordance with the provisions of Title 33, chapter  
11 22, part 7;

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

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

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

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

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

22 (ii) routine immunizations according to the schedule for immunization recommended by the  
23 advisory committee on immunization practices of the U.S. department of health and human services.

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

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

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

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

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

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

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

16          (12)    (a) (i) The state employee group benefit plans and the Montana university system group  
17    benefits plans must provide coverage for medically necessary and prescribed outpatient self-management  
18    training and education for the treatment of diabetes. Any education must be provided by a licensed health care  
19    professional with expertise in diabetes. At a minimum, the benefit must consist of:

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

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

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

25           (b)     The state employee group benefit plans and the Montana university system group benefits  
26    plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes,  
27    injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips,  
28    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) (i) 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.

(ii) Coverage of continuous glucose monitors and monitor supplies must be provided if an individual is diagnosed with type I or type II diabetes and a continuous glucose monitor is determined medically necessary by the insured's health care provider and prescribed by the health care provider acting within the scope of the provider's license. Coverage may not be limited based on the stage of the insured's disease of diabetes or the insured's diagnosed need for insulin.

(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

1 dependent only if:

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

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

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

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

11 (15) An insurance contract or plan issued under this part and a group benefits plan issued by the  
12 Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter  
13 22, part 7.

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

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

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

23 (c) pay the COBRA premium for 4 months of COBRA continuation coverage for the officer and the  
24 officer's covered spouse or dependent children enrolled in COBRA continuation coverage pursuant to  
25 subsections (16)(a) or (16)(b), after which time the officer and the officer's spouse or dependent children shall  
26 pay the COBRA premium. (See compiler's comments for contingent termination of certain text.)"

27

28 **Section 3.** Section 33-22-129, MCA, is amended to read:

1           **"33-22-129. Coverage for treatment of diabetes -- outpatient self-management training and**  
2   **education -- limited benefit for medically necessary equipment and supplies -- limitations on cost-**  
3   **sharing requirements for insulin.** (1) Each group disability policy, certificate of insurance, and membership  
4   contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide  
5   coverage for outpatient self-management training and education for the treatment of diabetes. Any education  
6   must be provided by a licensed health care professional with expertise in diabetes.

7           (2) (a) Coverage must include an annual benefit for medically necessary and prescribed outpatient  
8   self-management training and education for the treatment of diabetes. At a minimum, the benefit must consist  
9   of:

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

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

14          (b) Nothing in subsection (2)(a) prohibits an insurer from providing a greater benefit.

15          (c) For the purposes of this subsection (2), the term "visit" refers to a period of 30 minutes.

16          (3) (a) Each group disability policy, certificate of insurance, and membership contract that is  
17   delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for diabetic  
18   equipment and supplies that is limited to insulin, syringes, injection aids, devices for self-monitoring of glucose  
19   levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin  
20   pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood  
21   sugar levels for each class of drug approved by the United States food and drug administration, and glucagon  
22   emergency kits.

23          (b) Coverage for insulin must limit the insured's required copayment or other cost-sharing  
24   requirement for insulin to \$35 for up to a 30-day supply of insulin, regardless of the amount or type of insulin  
25   prescribed. The limitation in this subsection (3)(b) applies to insulin covered by the insurer's or group health  
26   plan's formulary.

27          (c) Coverage of continuous glucose monitors and monitor supplies must be provided if an  
28   individual is diagnosed with type I or type II diabetes and a continuous glucose monitor is determined medically

1 necessary by the insured's health care provider and prescribed by the health care provider acting within the  
2 scope of the provider's license. Coverage may not be limited based on the stage of the insured's disease of  
3 diabetes or the insured's diagnosed need for insulin.

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

6 (5) This section does not apply to disability income, hospital indemnity, medicare supplement,  
7 accident-only, vision, dental, specific disease, or long-term care policies.

8 (6) (a) This section does not apply to any employee group insurance program of a city, town,  
9 county, school district, or other political subdivision of this state that on January 1, 2002, provides substantially  
10 equivalent or greater coverage for outpatient self-management training and education for the treatment of  
11 diabetes and certain diabetic equipment and supplies provided for in subsection (3).

12 (b) Any employee group insurance program of a city, town, county, school district, or other political  
13 subdivision of this state that reduces or discontinues substantially equivalent or greater coverage after January  
14 1, 2002, is subject to the provisions of this section."  
15

16 NEW SECTION. Section 4. Codification instruction. [Section 1] is intended to be codified as an  
17 integral part of Title 33, chapter 22, part 3, and the provisions of Title 33, chapter 22, part 3, apply to [section 1].  
18

19 NEW SECTION. Section 5. Effective date. [This act] is effective January 1, 2026.  
20

21 NEW SECTION. Section 6. Appropriation. There is appropriated \$25,000 from the general fund to  
22 the department of administration for the biennium beginning July 1, 2025, for the purposes of administering the  
23 state employee health plan and [this act].  
24

25 NEW SECTION. Section 7. Applicability. [This act] applies to policies, certificates, and contracts  
26 issued or renewed on or after January 1, 2026.  
27

- END -