SENATE BILL NO. 449

INTRODUCED BY V. RICCI, C. SCHOMER, E. BUTTREY, J. ETCHART, L. DEMING, J. KARLEN

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH UTILIZATION REVIEW LAWS; PROVIDING FOR CONTINUING APPROVAL FOR ENROLLEES CHANGING HEALTH PLANS; GENERALLY PROHIBITING PRIOR AUTHORIZATION FOR PRESCRIPTIONS WRITTEN AT DISCHARGE FROM INPATIENT CARE; GENERALLY PROHIBITING RETROACTIVE DENIAL; PROVIDING REQUIREMENTS FOR ACCEPTING AND RESPONDING TO PRIOR AUTHORIZATION REQUESTS; PROVIDING A DEFINITION; AND PROVIDING AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Continuity of approval for enrollees changing health plans.** (1) On receipt of information documenting a prior authorization of approval from an enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer or its contracted utilization review organization shall honor a prior authorization granted to an enrollee from a previous health insurance issuer or its contracted utilization review organization for at least the initial 90 days of an enrollee's coverage under a new health plan, subject to the terms of the member's coverage agreement.

(2) During the time period described in section (1), a health insurance issuer or its contracted utilization review organization may perform its own review to grant a prior authorization approval subject to the terms of the member's coverage agreement.

(3) If there is a change in coverage of or approval criteria for a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization approval before the effective date of the change for the remainder of the enrollee's plan year.

(4) A health insurance issuer or its utilization review organization shall continue to honor a certification it has granted to a covered person when the person changes to a product offered by the same health insurance issuer, provided that the services are covered under the new plan.

(5) Nothing in this section may require a policy to cover any care, treatment, or services for a

health condition that the terms of coverage otherwise completely excluded from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

(6) No enrollee may be required to repeat a step therapy protocol if the enrollee, while under the enrollee's current or a previous health plan, used the prescription drug required by the step therapy protocol or another prescription drug in the same pharmacologic class with a similar efficacy and side effect profile or with the same mechanism of action and discontinued use of the drug due to lack of efficacy, effectiveness, an adverse event, or contraindication. The enrollee's prescribing provider shall submit justification and clinical information, if requested, that demonstrates a clinically valid reason for why the covered prescribed drug is needed and documentation of completion of previous step therapy protocols for the prescribed drug.

(7) As used in this section, "step therapy protocol" means an evidence-based protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are considered medically appropriate for a particular patient and are covered by a health insurer or health benefit plan.

NEW SECTION. **Section 2. Prohibition on prior authorization requirements for prescriptions written at discharge from inpatient care.** (1) A prescription written for an inpatient and patient under observation at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and must be immediately approved for not less than 3 days, provided that:

(a) the cost of the medication does not exceed $5,000 a day; and

(b) the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge.

(2) Approval beyond 3 days is subject to prior authorization review under 33-32-212.

NEW SECTION. **Section 3. Prohibition on retroactive denial.** When prior authorization for a covered service is required of and obtained by or on behalf of a member, the approval is final and may not be rescinded after the covered service has been provided. This section does not apply to cases of fraud, misrepresentation, nonpayment of premium, and exhaustion of benefits or if the member for whom the prior approval was granted is not covered when the service is provided.

NEW SECTION. **Section 4. Required method of accepting prior authorization requests.** (1) A health insurance issuer or utilization review organization shall accept and respond electronically to prior authorization requests from a health care provider submitted through a secure electronic transmission as determined by the health insurance issuer or utilization review organization.

(2) If a prior authorization for a prescription drug is submitted electronically using the national council for prescription drug program's ~~SCRIPT~~ standard for electronic prior authorization transactions, then the health insurance issuer or utilization review organization shall accept and respond to the prior authorization request using the same ~~SCRIPT~~ standard for electronic prior authorization transactions.

(3) This section does not require a health care professional to submit prior authorization requests electronically.

NEW SECTION. **Section 5. Codification instruction.** [Sections 1 through 4] are intended to be codified as an integral part of Title 33, chapter 32, and the provisions of Title 33, chapter 32, apply to [sections 1 through 4].

COORDINATION SECTION. **Section 6. Coordination instruction.** (1) If both House Bill 544 and [this act] are passed and approved, then [section 3 of this act] is void.

(2) If both House Bill 398 and [this act] are passed and approved, then [section 1 of ~~House Bill 398~~ this act] is void.

NEW SECTION. **Section 7. Applicability.** [This act] applies to policies or agreements to provide coverage for health care services issued or renewed on or after [the effective date of this act].

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