SENATE BILL NO. 380

INTRODUCED BY J. SMALL

A BILL FOR AN ACT ENTITLED: “AN ACT GENERALLY REVISING HEALTH CARE INSURANCE LAWS; PROVIDING FOR PRIOR AUTHORIZATION REQUIREMENTS; PROVIDING EXEMPTIONS; PROVIDING FOR A PROVIDER'S RIGHT TO AN EXTERNAL REVIEW; REVISING UTILIZATION REVIEW AND GRIEVANCE PROCEDURES; AMENDING SECTION 33-32-309, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE.”

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

NEW SECTION. **Section 1. Prior authorization requirements.** (1) A health insurance issuer may not perform prior authorization on benefits for:

(a) generic prescription drugs that are not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32;

(b) any prescription drug, generic or brand name, that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the drug without interruption for 6 months;

(c) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication if the covered person has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the prescription drug or drugs was approved;

(d) any prescription drug, generic or brand name, solely because the dosage of the medication for the covered person has been adjusted by the prescriber of the prescription drug; or

(e) any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.

(2) Any adverse determination for a prescription drug made during prior authorization by a health

insurance issuer must be made by:

(a) a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization; or

(b) a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination does not require the involvement of a physician on the part of a health insurance issuer.

(3) (a) A health insurance issuer may not perform retrospective review on any benefits when:

(i) payment has already been furnished to the provider of a health care service unless the health insurance issuer has a credible reason to believe that fraud or other illegal activity may have occurred involving the health care service for which payment has been furnished; or

(ii) a health care service has been previously approved and deemed medically necessary during prior authorization or concurrent review, provided that the health insurance issuer may perform retrospective review if the health care service was delivered in a manner that exceeded the scope or duration of what was approved during prior authorization or concurrent review.

(b) Retrospectively reviewing approved, paid, or pending claims or authorizations of health care services for the purposes of informing future utilization review activities is not considered a form of retrospective review.

NEW SECTION. **Section 2. Exemption from prior authorization requirements.** (1) A health insurance issuer that uses a prior authorization process for benefits may not require a provider to obtain prior authorization for a particular benefit if, in the most recent 6-month evaluation period, as described in subsection (2), the health insurance issuer has approved or would have approved not less than 90% of the prior authorization requests submitted by the provider for the particular benefit.

(2) Except as provided by subsection (3), a health insurance issuer shall evaluate whether a provider qualifies for an exemption from prior authorization requirements under subsection (1) once every 6 months.

(3) A health insurance issuer may continue an exemption under subsection (1) without evaluating whether the provider qualifies for the exemption under subsection (1) for a particular evaluation period.

(4) A provider is not required to request an exemption under subsection (1) to qualify for the exemption.

(5) A provider's exemption from prior authorization requirements under subsection (1) remains in effect until:

(a) the 30th day after the date the health insurance issuer notifies the provider of the issuer's determination to rescind the exemption under subsection (1), if the provider does not appeal the issuer's determination; or

(b) if the provider appeals the determination, the fifth day after the date an independent review organization affirms the issuer's determination to rescind the exemption.

(6) If a health insurance issuer does not finalize a rescission determination as specified in subsection (5), then the provider is considered to have met the criteria under subsection (1) to continue to qualify for the exemption.

(7) A health insurance issuer may rescind an exemption from prior authorization requirements under subsection (1) only:

(a) during January or June of each year;

(b) if the health insurance issuer makes a determination, on the basis of an examination of a random sample of not fewer than 20 and no more than 50 claims submitted by the provider during the most recent evaluation period described by subsection (2), that less than 90% of the claims for the particular benefit met the medical necessity criteria that would have been used by the health insurance issuer when conducting prior authorization review for the particular benefit during the relevant evaluation period; and

(c) if the health insurance issuer complies with other applicable requirements specified in this section, including:

(i) notifying the provider not less than 25 days before the proposed rescission is to take effect; and

(ii) providing with the notice under subsection (7)(c)(i):

(A) the sample information used to make the determination under subsection (7)(b); and

(B) a plain language explanation of how the provider may appeal and seek an independent review of the determination.

(8) A determination made under subsection (7)(b) must be made by an individual licensed to practice medicine under Title 37, chapter 3. For a determination made under subsection (7)(b) with respect to a physician, the determination must be made by an individual licensed to practice medicine under Title 37, chapter 3, who has the same or similar specialty as that physician.

(9) A health insurance issuer may deny an exemption from prior authorization requirements under subsection (1) only if:

(a) the provider does not have the exemption at the time of the relevant evaluation period; and

(b) the health insurance issuer provides the provider with actual statistics and data for the relevant prior authorization request evaluation period and detailed information sufficient to demonstrate that the provider does not meet the criteria for an exemption from prior authorization requirements for the particular benefit under subsection (1).

(10) A health insurance issuer may not deny or reduce payment to a provider for a benefit for which the provider has qualified for an exemption from prior authorization requirements under subsection (1) based on medical necessity or appropriateness of care unless the provider:

(a) knowingly and materially misrepresented the benefit in a request for payment submitted to the health insurance issuer with the specific intent to deceive and obtain an unlawful payment from the issuer; or

(b) failed to substantially furnish or deliver the benefit.

(11) A health insurance issuer may not conduct a retrospective review of a benefit subject to an exemption except:

(a) to determine if the provider still qualifies for an exemption under this section; or

(b) if the health insurance issuer has a reasonable cause to suspect a basis for denial exists under subsection (10).

(12) Not later than 5 days after qualifying for an exemption from prior authorization requirements under subsection (1), a health insurance issuer must provide to a provider a notice that includes:

(a) a statement that the provider qualifies for an exemption from prior authorization requirements under subsection (1);

(b) a list of the benefits to which the exemption applies; and

(c) a statement of the duration of the exemption.

(13) If a provider submits a prior authorization request for a benefit for which the provider qualifies for an exemption from prior authorization requirements under subsection (1), the health insurance issuer shall promptly provide a notice to the provider that includes:

(a) the information described by subsection (12); and

(b) a notification of the health insurance issuer's payment requirements.

(14) Nothing in this section may be construed to:

(a) authorize a provider to provide a health care service outside the scope of the provider's applicable license issued under Title 37; or

(b) require a health insurance issuer to pay for a benefit that is performed in violation of the laws of this state.

NEW SECTION. **Section 3. Provider right to external review.** (1) Notwithstanding any other provision of this part, a provider has the right to an independent external review of an adverse determination regarding a prior authorization exemption under Title 33, chapter 32, part 2, conducted by an independent review organization. A health insurance issuer may not require a provider to engage in an internal grievance process before requesting a review by an independent review organization under this part.

(2) A health insurance issuer shall pay:

(a) for any independent external review of an adverse determination regarding a prior authorization exemption requested under this section; and

(b) a reasonable fee determined by the Montana board of medical examiners for any copies of medical records or other documents requested from a provider during an exemption rescission independent external review requested under this section.

(3) An independent review organization shall complete a review of an adverse determination regarding a prior authorization exemption not later than the seventh day after the date a provider files the request for an independent external review under this section.

(4) A provider may request that the independent review organization consider another random sample of not less than 20 and no more than 50 claims submitted to the health insurance issuer by the provider during the relevant evaluation period for the relevant health care service as part of its review. If the provider

makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health insurance issuer under Title 33, chapter 32, part 2, and reviewed under this subsection.

(5) A health insurance issuer is bound by an independent external review determination that does not affirm the determination made by the health insurance issuer to rescind a prior authorization exemption.

(6) A health insurance issuer may not retrospectively deny a benefit based on a rescission of an exemption, even if the health insurance issuer's determination to rescind the prior authorization exemption is affirmed by an independent review organization.

(7) If a determination of a prior authorization exemption made by the health insurance issuer is overturned on review by an independent review organization, the health insurance issuer:

(a) may not attempt to rescind the exemption before the end of the next evaluation period that occurs; and

(b) may only rescind the exemption after if the entity complies with the previous provisions of this section.

Section 4. Section 33-32-309, MCA, is amended to read:

"**33-32-309. Expedited review of grievance involving adverse determination.** (1) A health insurance issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination, and separate written procedures for the expedited review of prescription drug grievances involving an adverse determination, as described in subsection (11).

(2) A health insurance issuer shall provide an expedited review of a grievance involving an adverse determination with respect to a concurrent review of an urgent care request involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. The procedures in subsection (1) must also specify the process for the concurrent review of urgent care requests under this subsection (2).

(3) The procedures under this section must provide that a covered person or, if applicable, the covered person's authorized representative may request an expedited review orally, in writing, or electronically.

(4) On receipt of a request for an expedited review, a health insurance issuer shall appoint one or

more physicians or health care professionals of the same licensure to review the adverse determination. An appointed physician or health care professional of the same licensure may not have been involved in making the initial adverse determination.

(5) In an expedited review, all necessary information, including the health insurance issuer's decision, must be transmitted between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative in the most expeditious method available, whether by telephone, facsimile, or other method.

(6) (a) The timeframe for making a decision under an expedited review and notification, as provided in subsection (8), must be as expeditious as the covered person's medical condition requires but may take no more than 72 hours after the receipt of the request for the expedited review.

(b) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the health insurance issuer shall continue the health care service or treatment without liability to the covered person until the covered person has been notified of the determination.

(7) For purposes of calculating the timeframe within which a decision is required to be made under subsection (6), the time period within which the decision must be made begins on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures for filing requests established under 33-32-307 without regard to whether all of the information necessary to make the determination accompanies the filing.

(8) A notification of a decision under this section must be in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative and, if necessary, meet the requirements of subsection (9). The notification must include:

(a) the titles and qualifying credentials of each physician or health care professional of the same licensure participating in the expedited review process;

(b) information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, and, if applicable, the claim amount;

(c) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A

health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for external review as outlined in Title 33, chapter 32, part 4.

(d) a statement from the physicians or health care professionals of the same licensure participating in the review of their understanding of the covered person's grievance;

(e) a description in clear terms of the decision of the physicians or health care professionals of the same licensure and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health insurance issuer's position;

(f) a reference to the evidence or documentation used as the basis for the decision. If the decision involves an adverse determination, the notice must provide:

(i) all specific reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in reaching the denial;

(ii) the reference to the specific plan provisions on which the determination is based;

(iii) if the adverse determination is based on incomplete documentation, a description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) a copy of any internal rule, guideline, protocol, or other similar criteria if relied on by the health insurance issuer to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(v) an explanation of the scientific or clinical judgment used for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. The explanation must apply the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request.

(vi) instructions for requesting any of the following that are applicable:

(A) a copy of the rule, guideline, protocol, or other similar criteria relied on in making the adverse

determination in accordance with subsection (8)(f)(iv); or

(B) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (8)(f)(v);

(vii) a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Title 33, chapter 32, part 4;

(viii) the following statement, if applicable:

"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner."

(ix) a statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction; and

(x) a notice of the covered person's right to contact the commissioner's office for assistance at any time, including the telephone number and address of the commissioner's office.

(9) The notice under subsection (8)(f) must be provided in accordance with federal regulations and as provided in 33-32-211(9).

(10) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within 3 days after the oral notification.

(11) (a) Notwithstanding any other provision of this part, any adverse determination for a prescription drug made during the course of prior authorization is eligible for an expedited review of a grievance, initiated by the prescriber of the prescription drug, if the prescriber of the prescription drug subject to prior authorization believes that, in the prescriber's professional judgment, the covered person will suffer serious harm without access to the prescription drug subject to prior authorization.

(b) On initiation of the expedited review of the grievance by the prescriber of the prescription drug subject to prior authorization, a health insurance issuer shall render a decision on the expedited review of the grievance within 48 hours and provide written notice.

(c) If a health insurance issuer does not render a decision on the expedited review of the grievance initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of

initiation, the initial adverse determination must be automatically overturned, and the covered person must be granted immediate approval for coverage of the prescription drug subject to prior authorization.

(d) The decision rendered during the expedited review of the grievance by a health insurance issuer must be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization or must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat."

NEW SECTION. **Section 5. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 32, part 2, and the provisions of Title 33, chapter 32, part 2, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 32, part 4, and the provisions of Title 33, chapter 32, part 4, apply to [section 3].

NEW SECTION. **Section 6. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 7. Applicability.** [This act] applies to policies and plans offered or sold on or after January 1, 2024.

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