

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

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2 NEW SECTION. Section 4. Required method of accepting prior authorization requests. (1) A

3 health insurance issuer or utilization review organization shall accept and respond electronically to prior  
4 authorization requests from a health care provider submitted through a secure electronic transmission as  
5 determined by the health insurance issuer or utilization review organization.

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

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

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13 NEW SECTION. Section 5. Codification instruction. [Sections 1 through 4] are intended to be  
14 codified as an integral part of Title 33, chapter 32, and the provisions of Title 33, chapter 32, apply to [sections  
15 1 through 4].

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

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

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

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