AN ACT REVISING LAWS RELATED TO HEALTH UTILIZATION REVIEW; REQUIRING A PHYSICIAN LICENSED IN THE STATE TO MAKE OR REVIEW AN ADVERSE DETERMINATION OR REVIEW A GRIEVANCE; AND AMENDING SECTION 33-32-221, MCA.

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

Section 1. Qualifications of individuals who make or review adverse determinations. (1) Only a physician may make an adverse determination pursuant to 33-32-211 or 33-32-212 for a utilization review organization.

(2) A physician who makes an adverse determination:

(a) must possess a current, valid nonrestricted license to practice medicine;

(b) must have a specialty that focuses on the diagnosis and treatment of the condition being reviewed; and

(c) shall make the adverse determination under the clinical direction of one of the utilization review organization's medical directors who is responsible for the oversight of the utilization review activities. A medical director used for this purpose must be a physician licensed in the state.

Section 2. Qualifications of individuals who review grievance. (1) Only a physician may review a grievance as provided under 33-32-308 or 33-32-309 for a utilization review organization.

(2) A physician who reviews a grievance:

(a) must possess a current, valid nonrestricted license to practice medicine;

(b) must have the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service that is the subject of the grievance;

(c) must have experience treating patients with the medical condition or disease that is the subject

of the grievance; and

(d) shall review the grievance under the clinical direction of one of the utilization review organization's medical directors who is responsible for the oversight of the utilization review activities. A medical director used for this purpose must be a physician licensed in the state.

(3) A physician who reviews a grievance may not:

(a) have been directly involved in making the adverse determination that is the subject of the grievance; and

(b) have a financial interest in the outcome of the grievance.

Section 3. Section 33-32-221, MCA, is amended to read:

"**33-32-221. Prior authorization requirements.** (1) A health insurance issuer may not perform prior authorization on benefits for:

(a) any generic prescription drug 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 covered drug at the same quantity without interruption for 6 months;

(b) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication for the same drug 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;

(c) 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, as long as the dosage is within the dosage approved by the food and drug administration or is consistent with clinical dosing for the medication; ~~or~~

(d) any prescription drug, generic or brand name, prescribed for treatment of a substance use disorder, provided that the drug is approved by the U.S. food and drug administration for treatment of substance use disorder and the prescription does not exceed the U.S. food and drug administration labeled dosages; or

~~(d)~~(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 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."

Section 4. Codification instruction. (1) [Section 1] is 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 [section 1].

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

Section 5. Coordination instruction. If both House Bill No. 398 and [this act] are passed and approved, then [sections 1 and 2 of this act] are void.

- END -

I hereby certify that the within bill,

SB 446, originated in the Senate.

_____

Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2025.

_____

Speaker of the House

Signed this _____day
of_____, 2025.

SENATE BILL NO. 446

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

AN ACT REVISING LAWS RELATED TO HEALTH UTILIZATION REVIEW; REQUIRING A PHYSICIAN LICENSED IN THE STATE TO MAKE OR REVIEW AN ADVERSE DETERMINATION OR REVIEW A GRIEVANCE; AND AMENDING SECTION 33-32-221, MCA.