HOUSE BILL NO. 364

AN ACT TO REQUIRE HEALTH BENEFIT PLANS THAT COVER
PRESCRIPTION DRUGS TO PROVIDE UNIFORM PRESCRIPTION IDENTIFICATION;
AND FOR RELATED PURPOSES.

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

SECTION 1. (1) Every health benefit plan that provides
coverage for prescription drugs or devices, or that administers
such a plan, including, but not limited to, health maintenance
organizations and third party administrators for self-insured
plans, shall issue to each insured a card or other technology
containing standardized pharmacy benefit identification
information. The card shall contain at a minimum the following
information:

(a) The card issuer's name or logo on the front of the
card;
(b) The cardholder's name and identification number,
which shall be displayed on the front side of the card;
(c) The American National Standards Institute Issuer
Identification Number assigned to the administrator or pharmacy
benefit manager of the plan, when required for proper claims
adjudication;
(d) The processor's control number, when required for
proper claims adjudication;
(e) The insured's group number, when required for
proper claims adjudication;
(f) The name and address of the benefits administrator
or other entity responsible for prescription claims submission,
adjudication or pharmacy provider correspondence for prescription

benefits; and

(g) A help desk telephone number that pharmacy

providers may call for pharmacy benefit claims assistance.

(2) This section does not require a health benefit plan to
issue an identification card separate from any identification card
issued to an enrollee to evidence coverage under the health
benefit plan if the identification card contains the elements
required by subsection (1) of this section.

(3) In order to ensure that insurance identification cards
issued under this section contain accurate and updated
information, each health benefit plan shall provide each
subscriber with a new insurance identification card within a
reasonable time after any information required for proper claims
adjudication is changed.

(4) As used in this section, "health benefit plan" means any
hospital or medical policy or certificate, hospital or medical
service contract or health maintenance organization, a plan
provided by a fully insured multiple employer welfare arrangement
or any other entity providing a plan of health insurance subject
to the jurisdiction of the Commissioner of Insurance and to the
extent permitted by the Employee Retirement Income Security Act of
1974, as amended, or by the Health Insurance Portability and
Accountability Act of 1996. A health benefit plan does not
include the following:

(a) Accident;

(b) Credit;

(c) Disability income;

(d) Long-term or nursing home care;

(e) Specified disease;

(f) Dental or vision;

(g) Coverage issued as a supplement to liability

insurance;
ST: Health insurance; require plans to provide uniform prescription identification.

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SECTION 1. (h) Medical payments under automobile or homeowners;

(i) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability or equivalent self-insurance; and

(j) Hospital income or indemnity.

(5) The Commissioner of Insurance may issue any rules or regulations necessary to implement the provisions of this act, and he may use the standards produced by the National Council for Prescription Drugs Programs as a guide in developing such rules and regulations.

(6) This act applies to plans that are delivered, issued for delivery or renewed on or after January 1, 2003. For purposes of this act, renewal of a health benefit policy, contract or plan is presumed to occur on the anniversary date.

SECTION 2. This act shall take effect and be in force from and after January 1, 2003.