By: Representatives Powell, Shanks, Kinkade, Steverson

To: Insurance

HOUSE BILL NO. 787

AN ACT TO PROHIBIT HEALTH INSURANCE PLANS FROM MODIFYING, ON RENEWAL, AN INSURED'S CONTRACTED BENEFIT LEVEL FOR ANY PRESCRIPTION DRUG THAT WAS APPROVED OR COVERED UNDER THE PLAN IN THE IMMEDIATELY PRECEDING PLAN YEAR AND PRESCRIBED DURING THAT YEAR FOR A MEDICAL CONDITION OR MENTAL ILLNESS; TO LIST MODIFICATIONS PROHIBITED; TO CLARIFY WHAT IS NOT PROHIBITED; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed on or after July 1, 2022, and providing coverage to any resident of this state may not modify, on renewal of the policy, plan or contract, an insured's contracted benefit level for any prescription drug that was approved or covered under the plan in

the immediately preceding plan year and prescribed during that year for a medical condition or mental illness if the insured (i) was covered by the policy, plan or contract on the date immediately preceding the renewal date, (ii) a physician or other prescribing provider prescribes the drug for the medical condition or mental illness; and (iii) the physician or other prescribing provider in consultation with the insured determines that the drug is the most appropriate course of treatment.

(2) Modifications prohibited under subsection (1) of this section include:

(a) Removing a drug from a formulary;

(b) Adding a requirement that an enrollee receive prior authorization for a drug;

(c) Imposing or altering a quantity limit for a drug;

(d) Imposing a step-therapy restriction for a drug;

(e) Moving a drug to a higher cost-sharing tier;

(f) Increasing a coinsurance, copayment, deductible, or other out-of-pocket expense that an enrollee must pay for a drug; and

(g) Reducing the maximum drug coverage amount.

(3) This section shall not be construed to prohibit a policy, plan or contract issuer from removing a drug from its formulary or denying an insured's coverage for the drug if:

(a) The United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug;

(b) The drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C, Federal Food, Drug, and Cosmetic Act (21 USC Section 356c); or

(c) The drug manufacturer has removed the drug from the market.

SECTION 2. This act shall take effect and be in force from and after July 1, 2022.