MISSISSIPPI LEGISLATURE

By: Senator(s) Michel, McLendon, Boyd, Horhn, DeLano, Hill, Parker, Jackson, Sparks

To: Insurance

COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 2622

1 AN ACT TO ENACT THE MISSISSIPPI PRIOR AUTHORIZATION REFORM 2 ACT; TO ESTABLISH THE LEGISLATIVE FINDINGS OF THE ACT; TO PROVIDE 3 THE APPLICABILITY AND SCOPE OF THE ACT; TO REQUIRE HEALTH 4 INSURANCE ISSUERS TO MAINTAIN A COMPLETE LIST OF SERVICES FOR 5 WHICH PRIOR AUTHORIZATIONS ARE REQUIRED; TO REQUIRE HEALTH 6 INSURANCE ISSUERS TO MAKE ANY CURRENT PRIOR AUTHORIZATION 7 REQUIREMENTS AND RESTRICTIONS READILY ACCESSIBLE AND POSTED ON ITS WEBSITE; TO SET REQUIREMENTS FOR THE CLINICAL REVIEW CRITERIA OF 8 9 HEALTH INSURANCE ISSUERS; TO PROHIBIT HEALTH INSURANCE ISSUERS 10 FROM DENYING A CLAIM FOR FAILURE TO OBTAIN PRIOR AUTHORIZATION IF 11 THE PRIOR AUTHORIZATION REQUIREMENT WAS NOT IN EFFECT ON THE DATE 12 OF SERVICE ON THE CLAIM; TO REQUIRE HEALTH INSURERS TO MAKE 13 CERTAIN PRIOR AUTHORIZATION STATISTICS AVAILABLE ON THEIR WEBSITE; TO REQUIRE HEALTH INSURANCE ISSUERS TO MAKE AVAILABLE A 14 15 STANDARDIZED ELECTRONIC PRIOR AUTHORIZATION REQUEST TRANSACTION 16 PROCESS BY JANUARY 1, 2024; TO ESTABLISH CERTAIN REQUIREMENTS ON 17 HEALTH INSURANCE ISSUERS FOR PRIOR AUTHORIZATIONS IN NONURGENT 18 CIRCUMSTANCES AND URGENT CIRCUMSTANCES; TO PROVIDE CERTAIN 19 QUALIFICATIONS OF PHYSICIANS QUALIFIED TO MAKE ADVERSE 20 DETERMINATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO GIVE 21 CERTAIN NOTIFICATIONS WHEN MAKING AN ADVERSE DETERMINATION; TO 22 ESTABLISH THE QUALIFICATIONS FOR PERSONNEL WHO REVIEW APPEALS OF 23 PRIOR AUTHORIZATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO 24 PERIODICALLY REVIEW ITS PRIOR AUTHORIZATION REQUIREMENTS AND TO 25 CONSIDER REMOVAL OF THESE REQUIREMENTS IN CERTAIN CASES; TO 26 PROVIDE THAT A HEALTH INSURANCE ISSUER MAY NOT REVOKE OR FURTHER 27 LIMIT, CONDITION OR RESTRICT A PREVIOUSLY ISSUED PRIOR 28 AUTHORIZATION WHILE IT REMAINS VALID UNDER THIS ACT UNLESS CERTAIN EXCLUSIONS ARE APPLICABLE; TO PROVIDE HOW LONG PRIOR AUTHORIZATION 29 30 APPROVALS SHALL BE VALID; TO PROVIDE HOW LONG THE PRIOR 31 AUTHORIZATIONS FOR CHRONIC CONDITIONS SHALL BE VALID; TO ESTABLISH 32 THE PROCEDURE FOR THE CONTINUITY OF PRIOR APPROVALS FROM PREVIOUS HEALTH INSURANCE ISSUERS TO CURRENT ISSUERS; TO PROVIDE THAT A 33 34 FAILURE BY A HEALTH INSURANCE ISSUER TO COMPLY WITH THE DEADLINES

S. B. No. 2622 23/SS36/R452CS PAGE 1 ~ OFFICIAL ~ G1/2

35 AND OTHER REQUIREMENTS SPECIFIED IN THIS ACT SHALL RESULT IN ANY 36 HEALTH CARE SERVICES SUBJECT TO REVIEW TO BE AUTOMATICALLY DEEMED 37 AUTHORIZED BY THE HEALTH INSURANCE ISSUER OR ITS CONTRACTED 38 PRIVATE REVIEW AGENT; TO AUTHORIZE THE DEPARTMENT OF HEALTH TO 39 ISSUE CEASE AND DESIST ORDERS TO HEALTH INSURANCE ISSUERS OR 40 PRIVATE REVIEW AGENTS; TO AUTHORIZE THE DEPARTMENT TO IMPOSE UPON 41 A PRIVATE REVIEW AGENT, HEALTH BENEFIT PLAN OR HEALTH INSURANCE 42 ISSUER AN ADMINISTRATIVE FINE NOT TO EXCEED \$10,000.00 PER 43 VIOLATION OF THE ACT; TO REQUIRE HEALTH INSURANCE ISSUERS TO REPORT TO THE DEPARTMENT CERTAIN DATA; TO AMEND SECTION 41-83-31, 44 45 MISSISSIPPI CODE OF 1972, TO CONFORM AND TO SET CERTAIN 46 QUALIFICATIONS AND TIME CONSTRAINTS FOR PHYSICIANS MAKING ADVERSE 47 DETERMINATIONS THROUGH ANY PROGRAM OF UTILIZATION REVIEW; TO AMEND 48 SECTION 83-9-6.3, MISSISSIPPI CODE OF 1972, TO CONFORM WITH THE 49 PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

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

51 <u>SECTION 1.</u> This act shall be known and may be cited as the 52 "Mississippi Prior Authorization Reform Act."

53 SECTION 2. Legislative Findings. The Mississippi

54 Legislature hereby finds and declares that:

(a) The health care professional-patient relationship
is paramount and should not be subject to unreasonable third-party
interference;

(b) Prior authorization programs may be subject to
member coverage agreements and medical policies but shall not
hinder the independent medical judgment of a physician or other

61 health care provider; and

62 (c) Prior authorization programs must be transparent to
63 ensure a fair and consistent process for health care providers and
64 their patients.

65 <u>SECTION 3.</u> Applicability and Scope. This act applies to 66 every health insurance issuer and all health benefit plans, as 67 both terms are defined in Section 83-9-6.3, and all private review

68 agents and utilization review plans, as both terms are defined in 69 Section 41-83-1, with the exception of employee or employer 70 self-insured health benefit plans under the federal Employee 71 Retirement Income Security Act of 1974, health care provided 72 pursuant to the Workers' Compensation Act or the Mississippi State 73 & School Employees' Life and Health Insurance Plan. This act does 74 not diminish the duties and responsibilities under other federal 75 or state law or rules promulgated thereunder applicable to a 76 health insurer, health insurance issuer, health benefit plan, 77 private review agent or utilization review plan, including but not 78 limited to the requirement of a certificate in accordance with Section 41-83-3. 79

80 <u>SECTION 4.</u> Definitions. For purposes of this act, unless 81 the context requires otherwise, the following terms shall have the 82 meanings ascribed herein:

83 (a) "Adverse determination" means a determination by a 84 health insurance issuer that, based upon the information provided, a request for a benefit under the health insurance issuer's health 85 86 benefit plan upon application of any utilization review technique 87 does not meet the health insurance issuer's requirements for 88 medical necessity, appropriateness, health care setting, level of 89 care, or effectiveness or is determined to be experimental or 90 investigational and the requested benefit is therefore denied, 91 reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or 92

~ OFFICIAL ~

93 termination of or failure to provide or make payment, in whole or 94 in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before 95 the effective date of coverage; or a rescission of coverage 96 97 determination, which does not include a cancellation or 98 discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of 99 100 coverage.

101 (b) "Appeal" means a formal request, either orally or102 in writing, to reconsider an adverse determination.

103 (c) "Approval" means a determination by a health 104 insurance issuer that a health care service has been reviewed and, 105 based on the information provided, satisfies the health insurance 106 issuer's requirements for medical necessity and appropriateness.

107 (d) "Clinical review criteria" means the written 108 screening procedures, decision abstracts, clinical protocols and 109 practice guidelines used by a health insurance issuer to determine 110 the necessity and appropriateness of health care services.

111 (e) "Department" means the Mississippi State Department 112 of Health.

(f) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and 117 medicine could reasonably expect the absence of immediate medical 118 attention to result in:

(i) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

122 (ii) Serious impairment to bodily functions; or
123 (iii) Serious dysfunction of any bodily organ or
124 part.

(g) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

128 (h) "Enrollee" means any person and his or her129 dependents enrolled in or covered by a health care plan.

(i) "Health care professional" means a physician, a
registered professional nurse or other individual appropriately
licensed or registered to provide health care services.

(j) "Health care provider" means any physician, hospital, ambulatory surgery center, or other person or facility that is licensed or otherwise authorized to deliver health care services.

(k) "Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or

142 healing human illness or injury, including behavioral health, 143 mental health, home health and pharmaceutical services and 144 products.

(1) "Health insurance issuer" has the meaning given to that term in Section 83-9-6.3. Any provision of this act that applies to a "health insurance issuer" also applies to any person or entity covered under the scope of this act in Section 3.

(m) "Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms and that are:

153 (i) In accordance with generally accepted154 standards of medical practice; and

(ii) Clinically appropriate in terms of type, frequency, extent, site and duration and are considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member or other interested party, but focused on what is best for the patient's health outcome.

162 (n) "Physician" means any person with a valid doctor of163 medicine, doctor of osteopathy or doctor of podiatry degree.

(o) "Prior authorization" means the process by which a
 health insurance issuer determines the medical necessity and
 medical appropriateness of an otherwise covered health care

167 service before the rendering of such health care service. "Prior 168 authorization" includes any health insurance issuer's requirement 169 that an enrollee, health care professional or health care provider 170 notify the health insurance issuer before, at the time of, or 171 concurrent to providing a health care service.

(p) "Urgent health care service" means a health care service with respect to which the application of the time periods for making a nonexpedited prior authorization that in the opinion of a treating health care professional or health care provider with knowledge of the enrollee's medical condition:

(i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

183 (q) "Urgent health care service" does not include184 emergency services.

185 (r) "Private review agent" has the meaning given to 186 that term in Section 41-83-1.

187 <u>SECTION 5.</u> Disclosure and review of prior authorization 188 requirements. (1) A health insurance issuer shall maintain a 189 complete list of services for which prior authorization is 190 required, including for all services where prior authorization is

191 performed by an entity under contract with the health insurance 192 issuer.

193 (2) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written 194 195 clinical review criteria, readily accessible and conspicuously 196 posted on its website to enrollees, health care professionals and 197 health care providers. Content published by a third party and 198 licensed for use by a health insurance issuer may be made 199 available through the health insurance issuer's secure, 200 password-protected website so long as the access requirements of 201 the website do not unreasonably restrict access. Requirements 202 shall be described in detail, written in easily understandable 203 language, and readily available to the health care professional 204 and health care provider at the point of care. The website shall 205 indicate for each service subject to prior authorization:

(a) When prior authorization became required for
policies issued or health benefit plan documents delivered in
Mississippi, including the effective date or dates and the
termination date or dates, if applicable, in Mississippi;

(b) The date the Mississippi-specific requirement was listed on the health insurance issuer's, health benefit plan's, or private review agent's website;

(c) Where applicable, the date that prior authorization was removed for Mississippi; and

(d) Where applicable, access to a standardized
electronic prior authorization request transaction process.
(3) The clinical review criteria must:

(a) Be based on nationally recognized, generally
accepted standards except where state law provides its own
standard;

(b) Be developed in accordance with the currentstandards of a national medical accreditation entity;

(c) Ensure quality of care and access to needed health care services;

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(d) Be evidence-based;

(e) Be sufficiently flexible to allow deviations fromnorms when justified on a case-by-case basis; and

(f) Be evaluated and updated, if necessary, at least annually.

(4) A health insurance issuer shall not deny a claim for
failure to obtain prior authorization if the prior authorization
requirement was not in effect on the date of service on the claim.

(5) A health insurance issuer shall not deem as incidental or deny supplies or health care services that are routinely used as part of a health care service when:

(a) An associated health care service has receivedprior authorization; or

(b) Prior authorization for the health care service isnot required.

240 (6) If a health insurance issuer intends either to implement 241 a new prior authorization requirement or restriction or amend an 242 existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted 243 health care providers of enrollees written notice of the new or 244 245 amended requirement or amendment no less than sixty (60) days 246 before the requirement or restriction is implemented. The written 247 notice may be provided in an electronic format, including email or 248 facsimile, if the health care professional or health care provider has agreed in advance to receive notices electronically. 249 The 250 health insurance issuer shall ensure that the new or amended 251 requirement is not implemented unless the health insurance 252 issuer's website has been updated to reflect the new or amended 253 requirement or restriction.

(7) Health insurers using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The statistics must be updated annually and include all of the following information:

(a) A list of all health care services, includingmedications, that are subject to prior authorization;

(b) The total number of prior authorization requestsreceived;

263 (c) The number of prior authorization requests denied264 during the previous plan year by the health insurance issuer,

S. B. No. 2622	~ OFFICIAL ~
23/SS36/R452CS	
PAGE 10	

265 health benefit plan, or private review agent with respect to each 266 service described in paragraph (a) of this subsection and the top 267 five (5) reasons for denial;

268 (d) The number of requests described in paragraph (c) 269 of this subsection that were appealed, the number of the appealed 270 requests that upheld the adverse determination and the number of appealed requests that reversed the adverse determination; 271

272 The average time between submission and response; (e) 273 and

274 (f) Any other information as the department determines 275 appropriate.

276 SECTION 6. Standardized electronic prior authorizations. Ιf 277 any health insurance issuer requires prior authorization of a 278 health care service the insurer or its designee utilization review organization shall, by January 1, 2024, make available a 279 280 standardized electronic prior authorization request transaction 281 process utilizing an internet webpage, internet webpage portal, or 282 similar electronic, internet, and web-based system.

283 SECTION 7. Prior authorizations in nonurgent circumstances. 284 Notwithstanding any other provision of law, if a health insurance 285 issuer requires prior authorization of a health care service, the 286 health insurance issuer must make an approval or adverse 287 determination and notify the enrollee, the enrollee's health care 288 professional, and the enrollee's health care provider of the approval or adverse determination as required by applicable law, 289

but no later than two (2) working days after obtaining all necessary information to make the approval or adverse determination. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required.

296 SECTION 8. Prior authorizations in urgent circumstances. 297 If requested by a treating health care provider or health (1)298 care professional for an enrollee, and notwithstanding any other 299 provision of law, a health insurance issuer must render an 300 approval or adverse determination concerning urgent health care 301 services and notify the enrollee, the enrollee's health care 302 professional and the enrollee's health care provider of that 303 approval or adverse determination as required by law, but not 304 later than twenty-four (24) hours after receiving all information 305 needed to complete the review of the requested health care 306 services.

307 (2) To facilitate the rendering of a prior authorization 308 determination in conformance with this section, a health insurance 309 issuer must establish a mechanism to ensure health care 310 professionals have access to appropriately trained and licensed 311 clinical personnel who have access to physicians for consultation, 312 designated by the plan to make such determinations for prior 313 authorization concerning urgent care services.

~ OFFICIAL ~

## 314 SECTION 9. Personnel qualified to make adverse

315 determinations. (1) A health insurance issuer must ensure that 316 all adverse determinations are made by a physician when the 317 request is by a physician or a representative of a physician. The 318 physician must:

319 (a) Possess a current and valid nonrestricted license320 in any United States jurisdiction; and

321 (b) Have experience treating and managing patients with 322 the medical condition or disease for which the health care service 323 is being requested.

324 (2) Notwithstanding the foregoing, the health insurance
325 issuer must also comply with Section 41-83-31 requiring
326 concurrence in the adverse determination by a physician licensed
327 to practice in Mississippi.

328 <u>SECTION 10.</u> Notifications for adverse determinations. If a 329 health insurance issuer makes an adverse determination, the health 330 insurance issuer shall include the following in the notification 331 to the enrollee, the enrollee's health care professional, and the 332 enrollee's health care provider:

(a) The reasons for the adverse determination and
related evidence-based criteria, including a description of any
missing or insufficient documentation;

336 (b) The right to appeal the adverse determination;337 (c) Instructions on how to file the appeal; and

338 (d) Additional documentation necessary to support the 339 appeal.

340 <u>SECTION 11.</u> Personnel qualified to review appeals. (1) A 341 health insurance issuer must ensure that all appeals are reviewed 342 by a physician when the request is by a physician or a 343 representative of a physician. The physician must:

(a) Possess a current and valid nonrestricted license
to practice medicine by the Mississippi State Board of Medical
Licensure;

(b) Be certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty of a physician who typically manages the medical condition or disease;

351 (c) Be knowledgeable of, and have experience providing,352 the health care services under appeal;

353 (d) Not have been directly involved in making the 354 adverse determination; and

(e) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the health insurance issuer by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer by the health care professional or health care provider.

362 (2) Notwithstanding the foregoing, a licensed health care 363 professional who satisfies the requirements in this section may 364 review appeal requests submitted by a health care professional 365 licensed in the same profession.

366 SECTION 12. Insurer review of prior authorization

367 requirements. A health insurance issuer shall periodically review 368 its prior authorization requirements and consider removal of prior 369 authorization requirements:

(a) Where a medication or procedure prescribed is
customary and properly indicated or is a treatment for the
clinical indication as supported by peer-reviewed medical
publications; or

374 (b) For patients currently managed with an established375 treatment regimen.

376 <u>SECTION 13.</u> Revocation of prior authorizations. (1) A 377 health insurance issuer may not revoke or further limit, condition 378 or restrict a previously issued prior authorization approval while 379 it remains valid under this act.

(2) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one (1) of the following occurs:

(a) It is timely determined that the enrollee's health
care professional or health care provider knowingly and without
exercising prudent clinical judgment provided health care services
that required prior authorization from the health insurance issuer
or its contracted private review agent without first obtaining
prior authorization for those health care services;

393 (b) It is timely determined that the health care394 services claimed were not performed;

(c) It is timely determined that the health care services rendered were contrary to the instructions of the health insurance issuer or its contracted private review agent or delegated reviewer if contact was made between those parties before the service being rendered;

400 (d) It is timely determined that the enrollee receiving
401 such health care services was not an enrollee of the health care
402 plan; or

403 The approval was based upon a material (e) 404 misrepresentation by the enrollee, health care professional, or 405 health care provider; as used in this paragraph, "material" means 406 a fact or situation that is not merely technical in nature and 407 results or could result in a substantial change in the situation. 408 Nothing in this section shall preclude a private review (3) 409 agent or a health insurance issuer from performing post-service 410 reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse. 411

S. B. No. 2622	~ OFFICIAL ~
23/SS36/R452CS	
PAGE 16	

412 SECTION 14. Length of approvals. (1) A prior authorization 413 approval shall be valid for the lesser of six (6) months after the date the health care professional or health care provider receives 414 415 the prior authorization approval or the length of treatment as 416 determined by the patient's health care professional or the 417 renewal of the plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a 418 prescription drug prescribed by the health care professional. 419 All 420 dosage increases must be based on established evidentiary standards and nothing in this section shall prohibit a health 421 422 insurance issuer from having safety edits in place. This section 423 shall not apply to the prescription of benzodiazepines or Schedule 424 II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

430 <u>SECTION 15.</u> Approvals for chronic conditions. (1) If a 431 health insurance issuer requires a prior authorization for a 432 recurring health care service or maintenance medication for the 433 treatment of a chronic or long-term condition, the approval shall 434 remain valid for the lesser of twelve (12) months from the date 435 the health care professional or health care provider receives the 436 prior authorization approval or the length of the treatment as

437 determined by the patient's health care professional. This 438 section shall not apply to the prescription of benzodiazepines or 439 Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

445 SECTION 16. Continuity of prior approvals. (1) On receipt 446 of information documenting a prior authorization approval from the 447 enrollee or from the enrollee's health care professional or health 448 care provider, a health insurance issuer shall honor a prior 449 authorization granted to an enrollee from a previous health 450 insurance issuer for at least the initial ninety (90) days of an enrollee's coverage under a new health plan, subject to the terms 451 452 of the member's coverage agreement.

453 (2) During the time period described in subsection (1) of 454 this section, a health insurance issuer may perform its own review 455 to grant a prior authorization approval subject to the terms of 456 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) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this section shall require a policy to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment or services are medically necessary.

468 <u>SECTION 17.</u> Effect of insurer's failure to comply. A 469 failure by a health insurance issuer to comply with the deadlines 470 and other requirements specified in this act shall result in any 471 health care services subject to review to be automatically deemed 472 authorized by the health insurance issuer or its contracted 473 private review agent.

474 SECTION 18. Enforcement and administration. (1) In 475 addition to the enforcement powers granted to it by law to enforce the provisions of this act, the department is hereby granted 476 477 specific authority to issue a cease-and-desist order or require a 478 private review agent or health insurance issuer to submit a plan 479 of correction for violations of this act, or both. Subject to 480 regulations promulgated by the department pursuant to provisions 481 of the Mississippi Administrative Procedure Law, the department 482 may impose upon a private review agent, health benefit plan or 483 health insurance issuer an administrative fine not to exceed Ten 484 Thousand Dollars (\$10,000.00) per violation for failure to submit 485 a requested plan of correction, failure to comply with its plan of 486 correction, or repeated violations of this act. The department

S. B. No. 2622 23/SS36/R452CS PAGE 19

## ~ OFFICIAL ~

487 may also exercise all authority granted to it pursuant to Section 488 41-83-13 to deny or revoke a certificate of a private review agent 489 for a violation of this act.

490 Any person or his or her treating physician who believes (2)491 that his or her health insurance issuer or health benefit plan is 492 in violation of the provisions of this act may file a complaint 493 with the department. The department shall review all complaints 494 received and investigate all complaints that it deems to state a 495 potential violation. The department shall fairly, efficiently and timely review and investigate complaints. Health insurance 496 497 issuers, health benefit plans and private review agents found to 498 be in violation of this act shall be penalized in accordance with 499 this section.

500 (3) The department shall have the authority to promulgate 501 rules and regulations pursuant to the Mississippi Administrative 502 Procedures Law to govern the administration of this act.

503 <u>SECTION 19.</u> Reports to the department. (1) By June 1, 504 2024, and each June 1 after that date, a health insurance issuer 505 shall report to the department, on a form issued by the 506 department, the following aggregated trend data related to the 507 insurer's practices and experience for the prior plan year for 508 health care services submitted for payment:

509 (a) The number of prior authorization requests;
510 (b) The number of prior authorization requests denied;
511 (c) The number of prior authorization appeals received;

512 (d) The number of adverse determinations reversed on 513 appeal;

(e) Of the total number of prior authorization
requests, the number of prior authorization requests that were not
submitted electronically;

517 (f) The ten (10) health care services that were most 518 frequently denied through prior authorization;

519 (g) The ten (10) reasons prior authorization requests 520 were most frequently denied;

521 (h) The number of claims for health care services that 522 were examined through a post-service utilization review process;

523 (i) The number and percentage of claims for health care 524 services denied through post-service utilization review; and

(j) The ten (10) health care services that were most frequently denied as a result of post-service utilization reviews. (2) All reports required by this section shall be considered public records pursuant to the Mississippi Public Records Act of 1983 and the department shall make all reports freely available to requestors and post all reports to its public website without

531 redactions.

532 SECTION 20. Section 41-83-31, Mississippi Code of 1972, is 533 amended as follows:

41-83-31. Any program of utilization review with regard tobospital, medical or other health care services provided in this

536 state, including, but not limited to, any prior authorization as
537 defined in Section 3 of this act, shall comply with the following:

538 No determination adverse to a patient or to any (a) 539 affected health care provider shall be made on any question 540 relating to the necessity or justification for any form of 541 hospital, medical or other health care services without prior 542 evaluation and concurrence in the adverse determination by a 543 physician licensed to practice in Mississippi and certified by the 544 board(s) of the American Board of Medical Specialists or the 545 American Board of Osteopathy within the relevant specialty. The 546 physician who made the adverse determination shall discuss the 547 reasons for any adverse determination with the affected health 548 care provider, if the provider so requests. The physician shall comply with this request within \* \* \* seven (7) calendar days of 549 being notified of a request. Adverse determination by a physician 550 551 shall not be grounds for any disciplinary action against the 552 physician by the State Board of Medical Licensure.

553 Any determination regarding hospital, medical or (b) 554 other health care services rendered or to be rendered to a patient 555 which may result in a denial of third-party reimbursement or a 556 denial of precertification for that service shall include the 557 evaluation, findings and concurrence of a physician trained in the 558 relevant specialty or subspecialty and certified by the board(s) 559 of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty, if requested by the 560

561 patient's physician, to make a final determination that care 562 rendered or to be rendered was, is, or may be medically 563 inappropriate.

(c) The requirement in this section that the physician
who makes the evaluation and concurrence in the adverse
determination must be licensed to practice in Mississippi shall
not apply to the Comprehensive Health Insurance Risk Pool
Association or its policyholders and shall not apply to any
utilization review company which reviews fewer than ten (10)
persons residing in the State of Mississippi.

571 SECTION 21. Section 83-9-6.3, Mississippi Code of 1972, is 572 amended as follows:

573 83-9-6.3. (1) As used in this section:

574 "Health benefit plan" means services consisting of (a) 575 medical care, provided directly, through insurance or 576 reimbursement, or otherwise, and including items and services paid 577 for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, 578 579 preferred provider organization, or health maintenance 580 organization contract offered by a health insurance issuer. The 581 term "health benefit plan" includes the Medicaid fee-for-service 582 program and any managed care program, coordinated care program, 583 coordinated care organization program or health maintenance 584 organization program implemented by the Division of Medicaid.

S. B. No. 2622 23/SS36/R452CS PAGE 23 ~ OFFICIAL ~

585 (b) "Health insurance issuer" means any entity that 586 offers health insurance coverage through a health benefit plan, policy, or certificate of insurance subject to state law that 587 588 regulates the business of insurance. "Health insurance issuer" 589 also includes a health maintenance organization, as defined and 590 regulated under Section 83-41-301 et seq., and includes the 591 Division of Medicaid for the services provided by fee-for-service 592 and through any managed care program, coordinated care program, 593 coordinated care organization program or health maintenance 594 organization program implemented by the division.

(c) "Prior authorization" means a utilization management criterion used to seek permission or waiver of a drug to be covered under a health benefit plan that provides prescription drug benefits.

(d) "Prior authorization form" means a standardized,
uniform application developed by a health insurance issuer for the
purpose of obtaining prior authorization.

602 (2) Notwithstanding any other provision of law to the 603 contrary, in order to establish uniformity in the submission of 604 prior authorization forms, on or after January 1, 2014, a health 605 insurance issuer shall use only a single, standardized prior 606 authorization form for obtaining any prior authorization for 607 prescription drug benefits. The form shall not exceed two (2) 608 pages in length, excluding any instructions or guiding 609 documentation. The form shall also be made available

~ OFFICIAL ~

610 electronically, and the prescribing provider may submit the 611 completed form electronically to the health benefit plan. 612 Additionally, the health insurance issuer shall submit its prior 613 authorization forms to the Mississippi Department of Insurance to 614 be kept on file on or after January 1, 2014. A copy of any 615 subsequent replacements or modifications of a health insurance 616 issuer's prior authorization form shall be filed with the 617 Mississippi Department of Insurance and the Mississippi State 618 Department of Health within fifteen (15) days prior to use or 619 implementation of such replacements or modifications.

620 (3) A health insurance issuer shall respond within two 621 (2) \* \* \* working days upon receipt of a completed prior 622 authorization request from a prescribing provider that was 623 submitted using the standardized prior authorization form required 624 by subsection (2) of this section. Notwithstanding any other 625 provision of law to the contrary, a health insurance issuer shall 626 comply with Section 8 of this act for all urgent health care 627 services and in conformity with Section 7 of this act for all 628 other prior authorization requests made by a prescribing provider. 629 SECTION 22. This act shall take effect and be in force from 630 and after July 1, 2023.

S. B. No. 2622 23/SS36/R452CS PAGE 25 ST: Mississippi Prior Authorization Reform Act; enact.