MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

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

To: Insurance

SENATE BILL NO. 2622
(As Sent to Governor)

AN ACT TO ENACT THE MISSISSIPPI PRIOR AUTHORIZATION REFORM ACT; TO ESTABLISH THE LEGISLATIVE FINDINGS OF THE ACT; TO PROVIDE THE APPLICABILITY AND SCOPE OF THE ACT; TO REQUIRE HEALTH INSURANCE ISSUERS TO MAINTAIN A COMPLETE LIST OF SERVICES FOR WHICH PRIOR AUTHORIZATIONS ARE REQUIRED; TO REQUIRE HEALTH INSURANCE ISSUERS TO MAKE ANY CURRENT PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS READILY ACCESSIBLE AND POSTED ON ITS WEBSITE; TO SET REQUIREMENTS FOR THE CLINICAL REVIEW CRITERIA OF HEALTH INSURANCE ISSUERS; TO PROHIBIT HEALTH INSURANCE ISSUERS FROM DENYING 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; TO REQUIRE HEALTH INSURERS TO MAKE CERTAIN PRIOR AUTHORIZATION STATISTICS AVAILABLE ON THEIR WEBSITE; TO REQUIRE HEALTH INSURANCE ISSUERS TO MAKE AVAILABLE A STANDARDIZED ELECTRONIC PRIOR AUTHORIZATION REQUEST TRANSACTION PROCESS BY JANUARY 1, 2024; TO REQUIRE ALL HEALTH CARE PROFESSIONALS AND HEALTH CARE PROVIDERS TO USE THAT PROCESS NOT LATER THAN JANUARY 1, 2026; TO ESTABLISH CERTAIN REQUIREMENTS ON HEALTH INSURANCE ISSUERS FOR PRIOR AUTHORIZATIONS IN NONURGENT CIRCUMSTANCES AND URGENT CIRCUMSTANCES; TO PROVIDE CERTAIN QUALIFICATIONS OF PHYSICIANS QUALIFIED TO MAKE ADVERSE DETERMINATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO GIVE CERTAIN NOTIFICATIONS WHEN MAKING AN ADVERSE DETERMINATION; TO ESTABLISH THE QUALIFICATIONS FOR PERSONNEL WHO REVIEW APPEALS OF PRIOR AUTHORIZATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO PERIODICALLY REVIEW ITS PRIOR AUTHORIZATION REQUIREMENTS AND TO CONSIDER REMOVAL OF THESE REQUIREMENTS IN CERTAIN CASES; TO PROVIDE THAT A HEALTH INSURANCE ISSUER MAY NOT REVOKE OR FURTHER LIMIT, CONDITION OR RESTRICT A PREVIOUSLY ISSUED PRIOR AUTHORIZATION WHILE IT REMAINS VALID UNDER THIS ACT UNLESS CERTAIN EXCLUSIONS ARE APPLICABLE; TO PROVIDE HOW LONG PRIOR AUTHORIZATION APPROVALS SHALL BE VALID; TO PROVIDE HOW LONG THE PRIOR AUTHORIZATIONS FOR CHRONIC CONDITIONS SHALL BE VALID; TO ESTABLISH THE PROCEDURE FOR THE CONTINUITY OF PRIOR APPROVALS FROM PREVIOUS

HEALTH INSURANCE ISSUERS TO CURRENT ISSUERS; TO PROVIDE THAT A FAILURE BY A HEALTH INSURANCE ISSUER TO COMPLY WITH THE DEADLINES AND OTHER REQUIREMENTS SPECIFIED IN THIS ACT SHALL RESULT IN ANY HEALTH CARE SERVICES SUBJECT TO REVIEW TO BE AUTOMATICALLY DEEMED AUTHORIZED BY THE HEALTH INSURANCE ISSUER OR ITS CONTRACTED PRIVATE REVIEW AGENT; TO AUTHORIZE THE DEPARTMENT OF HEALTH TO ISSUE CEASE AND DESIST ORDERS TO HEALTH INSURANCE ISSUERS OR PRIVATE REVIEW AGENTS; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO IMPOSE UPON A PRIVATE REVIEW AGENT, HEALTH BENEFIT PLAN OR HEALTH INSURANCE ISSUER AN ADMINISTRATIVE FINE NOT TO EXCEED $10,000 PER VIOLATION OF THE ACT; TO REQUIRE HEALTH INSURANCE ISSUERS TO REPORT TO THE DEPARTMENT CERTAIN DATA; TO REQUIRE HEALTH INSURANCE ISSUERS TO NOTIFY THE COMMISSIONER OF INSURANCE OF SUSPECTED SUBMISSIONS OF FALSE REQUESTS FOR PRIOR AUTHORIZATION; TO REQUIRE THE COMMISSIONER TO HAVE AN ADMINISTRATIVE HEARING ON SUCH MATTERS TO RESOLVE THE ISSUE; TO AMEND SECTION 41-83-31, MISSISSIPPI CODE OF 1972, TO CONFORM AND TO SET CERTAIN QUALIFICATIONS AND TIME CONSTRAINTS FOR PHYSICIANS MAKING ADVERSE DETERMINATIONS THROUGH ANY PROGRAM OF UTILIZATION REVIEW; TO AMEND SECTION 83-9-6.3, MISSISSIPPI CODE OF 1972, TO CONFORM WITH THE PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

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

SECTION 1. This act shall be known and may be cited as the "Mississippi Prior Authorization Reform Act."

SECTION 2. Legislative findings. The Mississippi Legislature 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 health care provider; and

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

SECTION 3. Applicability and scope. This act applies to every health insurance issuer and all health benefit plans, as both terms are defined in Section 83-9-6.3, and all private review agents and utilization review plans, as both terms are defined in Section 41-83-1, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974, health care provided pursuant to the Workers' Compensation Act or the Mississippi State and School Employees' Life and Health Insurance Plan. This act does not diminish the duties and responsibilities under other federal or state law or rules promulgated under those laws applicable to a health insurer, health insurance issuer, health benefit plan, private review agent or utilization review plan, including, but not limited to, the requirement of a certificate in accordance with Section 41-83-3.

SECTION 4. Definitions. For purposes of this act, unless the context requires otherwise, the following terms shall have the meanings as defined in this section:

(a) "Adverse determination" means a determination by a health insurance issuer that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or

investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

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

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

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

(e) "Department" means the State Department 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 medicine could reasonably expect the absence of immediate medical 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;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

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

(h) "Enrollee" means any person and his or her 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 healing human illness or injury, including behavioral health, mental health, home health and pharmaceutical services and products.

(l) "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 of this act.

(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:

(i) In accordance with generally accepted 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.

(n) "Physician" means any person with a valid doctor of 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 service before the rendering of such health care service. "Prior authorization" includes any health insurance issuer's requirement that an enrollee, health care professional or health care provider notify the health insurance issuer before, at the time of, or 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.

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

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

SECTION 5. Disclosure and review of prior authorization requirements. (1) A health insurance issuer shall maintain a

complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer.

(2) A health insurance issuer shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals and health care providers. Content published by a third party and licensed for use by a health insurance issuer may be made available through the health insurance issuer's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall 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 current standards of a national medical accreditation entity;

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

(d) Be evidence-based;

(e) Be sufficiently flexible to allow deviations from norms 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 received prior authorization; or

(b) Prior authorization for the health care service is not required.

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

(b) The total number of prior authorization requests received;

(c) The number of prior authorization requests denied during the previous plan year by the health insurance issuer, health benefit plan, or private review agent with respect to each service described in paragraph (a) of this subsection and the top five (5) reasons for denial;

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

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

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

SECTION 6. Standardized electronic prior authorizations. (1) If any health insurance issuer requires prior authorization of a health care service, the insurer or its designee utilization review organization shall, by January 1, 2024, make available a standardized electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(2) Not later than January 1, 2026, all health care professionals and health care providers shall be required to use the standardized electronic prior authorization request transaction process made available as required by subsection (1) of this section.

SECTION 7. **Prior authorizations in nonurgent circumstances.** If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as required by applicable law, 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.

SECTION 8. **Prior authorizations in urgent circumstances.** (1) If requested by a treating health care provider or health care professional for an enrollee, a health insurance issuer must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as required by law, but not later than twenty-four (24) hours after receiving all information needed to complete the review of the requested health care services.

(2) To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care

professionals have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services.

SECTION 9. Personnel qualified to make adverse determinations. (1) A health insurance issuer must ensure that all adverse determinations are made by a physician when the request is by a physician or a representative of a physician. The physician must:

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

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

(2) Notwithstanding the foregoing, the health insurance issuer must also comply with Section 41-83-31 requiring concurrence in the adverse determination by a physician certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty.

SECTION 10. Notifications for adverse determinations. If a health insurance issuer makes an adverse determination, the health insurance issuer shall include the following in the notification to the enrollee, the enrollee's health care professional, and the 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;

(b) The right to appeal the adverse determination;

(c) Instructions on how to file the appeal; and

(d) Additional documentation necessary to support the appeal.

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

(a) Possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;

(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;

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

(d) Not have been directly involved in making the 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.

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

SECTION 12. Insurer review of prior authorization requirements. A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior 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

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

SECTION 13. Revocation of prior authorizations. (1) A health insurance issuer may not revoke or further limit, condition or restrict a previously issued prior authorization approval while 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;

(b) It is timely determined that the health care 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;

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

(e) The approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(3) Nothing in this section shall preclude a private review agent or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

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

SECTION 15. Approvals for chronic conditions. (1) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the

treatment of a chronic or long-term condition, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. This section shall not apply to the prescription of benzodiazepines or Schedule 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.

SECTION 16. Continuity of prior approvals. (1) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer for at least the initial ninety (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 subsection (1) of this section, a health insurance issuer 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) Except to the extent required by medical exceptions processes for prescription drugs, 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.

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

SECTION 18. Enforcement and administration. (1) In addition to the enforcement powers granted to it by law to enforce the provisions of this act, the department is granted specific authority to issue a cease-and-desist order or require a private review agent or health insurance issuer to submit a plan of correction for violations of this act, or both. Subject to regulations promulgated by the department under the provisions of

the Mississippi Administrative Procedure Law, the department may impose upon a private review agent, health benefit plan or health insurance issuer an administrative fine not to exceed Ten Thousand Dollars ($10,000.00) per violation for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this act. All fines collected by the department under this section shall be deposited into the State General Fund. The department may also exercise all authority granted to it under Section 41-83-13 to deny or revoke a certificate of a private review agent for a violation of this act.

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

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

SECTION 19. Reports to the department. (1) By June 1, 2024, and each June 1 after that date, a health insurance issuer

shall report to the department, on a form issued by the department, the following aggregated trend data related to the insurer's practices and experience for the prior plan year for health care services submitted for payment:

(a) The number of prior authorization requests;

(b) The number of prior authorization requests denied;

(c) The number of prior authorization appeals received;

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

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

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

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

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

(i) The number and percentage of claims for health care 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 under 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 redactions.

SECTION 20. False requests for prior authorization. If a health insurance issuer has reason to believe that a health care professional or health care provider has knowingly and willingly submitted false or fraudulent requests for prior authorization to the health insurance issuer, the issuer shall notify and provide that information to the Commissioner of Insurance. After receipt of such notification and information, the commissioner shall have an administrative hearing on the matter to resolve the issue.

SECTION 21. Section 41-83-31, Mississippi Code of 1972, is amended as follows:

41-83-31. Any program of utilization review with regard to hospital, medical or other health care services provided in this state, including, but not limited to, any prior authorization as defined in Section 4 of this act, shall comply with the following:

(a) No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in * * * any United States jurisdiction and certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty. The physician who made the adverse

determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within * * * seven (7) calendar days of being notified of a request. Adverse determination by a physician shall not be grounds for any disciplinary action against the physician by the State Board of Medical Licensure.

(b) Any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service shall include the evaluation, findings and concurrence of a physician trained in the relevant specialty or subspecialty and certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty, if requested by the patient's physician, to make a final determination that care rendered or to be rendered was, is, or may be medically 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.

SECTION 22. Section 83-9-6.3, Mississippi Code of 1972, is amended as follows:

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

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

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

(2) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2014, a health insurance issuer shall use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation. The form shall also be made available electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan. Additionally, the health insurance issuer shall submit its prior authorization forms to the Mississippi Department of Insurance to be kept on file on or after January 1, 2014. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Mississippi Department of Insurance and the State Department of Health within fifteen (15) days prior to use or implementation of such replacements or modifications.

(3) A health insurance issuer shall respond within two (2) * * * working days upon receipt of a completed prior authorization request from a prescribing provider that was submitted using the standardized prior authorization form required by subsection (2) of this section. A health insurance issuer shall comply with Section 8 of this act for all urgent health care services and in conformity with Section 7 of this act for all other prior authorization requests made by a prescribing provider.

SECTION 23. This act shall take effect and be in force from and after July 1, 2023.