

By: Senator(s) Michel, Younger, Wiggins, Thomas, Whaley, Frazier, McLendon, DeLano, Boyd, Sparks, Hill, Horhn, Norwood, Simmons (12th), Chassaniol, Branning, Brumfield, Parker, Simmons (13th)

To: Insurance

SENATE BILL NO. 2140

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
8 WEBSITE; TO SET REQUIREMENTS FOR THE CLINICAL REVIEW CRITERIA OF
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;
14 TO REQUIRE HEALTH INSURANCE ISSUERS TO MAKE AVAILABLE A
15 STANDARDIZED ELECTRONIC PRIOR AUTHORIZATION REQUEST TRANSACTION
16 PROCESS BY JANUARY 1, 2025; TO REQUIRE ALL HEALTH CARE
17 PROFESSIONALS AND HEALTH CARE PROVIDERS TO USE THAT PROCESS NOT
18 LATER THAN JANUARY 1, 2027; TO ESTABLISH CERTAIN REQUIREMENTS ON
19 HEALTH INSURANCE ISSUERS FOR PRIOR AUTHORIZATIONS IN NONURGENT
20 CIRCUMSTANCES AND URGENT CIRCUMSTANCES; TO PROVIDE CERTAIN
21 QUALIFICATIONS OF PHYSICIANS QUALIFIED TO MAKE ADVERSE
22 DETERMINATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO GIVE
23 CERTAIN NOTIFICATIONS WHEN MAKING AN ADVERSE DETERMINATION; TO
24 ESTABLISH THE QUALIFICATIONS FOR PERSONNEL WHO REVIEW APPEALS OF
25 PRIOR AUTHORIZATIONS; TO REQUIRE HEALTH INSURANCE ISSUERS TO
26 PERIODICALLY REVIEW ITS PRIOR AUTHORIZATION REQUIREMENTS AND TO
27 CONSIDER REMOVAL OF THESE REQUIREMENTS IN CERTAIN CASES; TO
28 PROVIDE THAT A HEALTH INSURANCE ISSUER MAY NOT REVOKE OR FURTHER
29 LIMIT, CONDITION OR RESTRICT A PREVIOUSLY ISSUED PRIOR
30 AUTHORIZATION WHILE IT REMAINS VALID UNDER THIS ACT UNLESS CERTAIN
31 EXCLUSIONS ARE APPLICABLE; TO PROVIDE HOW LONG PRIOR AUTHORIZATION
32 APPROVALS SHALL BE VALID; TO PROVIDE HOW LONG THE PRIOR
33 AUTHORIZATIONS FOR CHRONIC CONDITIONS SHALL BE VALID; TO ESTABLISH
34 THE PROCEDURE FOR THE CONTINUITY OF PRIOR APPROVALS FROM PREVIOUS



35 HEALTH INSURANCE ISSUERS TO CURRENT ISSUERS; TO PROVIDE THAT A
36 FAILURE BY A HEALTH INSURANCE ISSUER TO COMPLY WITH THE DEADLINES
37 AND OTHER REQUIREMENTS SPECIFIED IN THIS ACT SHALL RESULT IN ANY
38 HEALTH CARE SERVICES SUBJECT TO REVIEW TO BE AUTOMATICALLY DEEMED
39 AUTHORIZED BY THE HEALTH INSURANCE ISSUER OR ITS CONTRACTED
40 PRIVATE REVIEW AGENT; TO AUTHORIZE THE DEPARTMENT OF INSURANCE TO
41 ISSUE CEASE AND DESIST ORDERS TO HEALTH INSURANCE ISSUERS OR
42 PRIVATE REVIEW AGENTS; TO AUTHORIZE THE STATE DEPARTMENT OF
43 INSURANCE TO IMPOSE UPON A PRIVATE REVIEW AGENT, HEALTH BENEFIT
44 PLAN OR HEALTH INSURANCE ISSUER AN ADMINISTRATIVE FINE NOT TO
45 EXCEED \$10,000 PER VIOLATION OF THE ACT; TO REQUIRE HEALTH
46 INSURANCE ISSUERS TO REPORT TO THE DEPARTMENT CERTAIN DATA; TO
47 REQUIRE HEALTH INSURANCE ISSUERS TO NOTIFY THE COMMISSIONER OF
48 INSURANCE OF SUSPECTED SUBMISSIONS OF FALSE REQUESTS FOR PRIOR
49 AUTHORIZATION; TO REQUIRE THE COMMISSIONER TO HAVE AN
50 ADMINISTRATIVE HEARING ON SUCH MATTERS TO RESOLVE THE ISSUE; TO
51 AMEND SECTION 41-83-31, MISSISSIPPI CODE OF 1972, TO CONFORM AND
52 TO SET CERTAIN QUALIFICATIONS AND TIME CONSTRAINTS FOR PHYSICIANS
53 MAKING ADVERSE DETERMINATIONS THROUGH ANY PROGRAM OF UTILIZATION
54 REVIEW; TO AMEND SECTIONS 41-83-1, 41-83-3, 41-83-13, 41-83-21,
55 83-1-101 AND 83-9-6.3 MISSISSIPPI CODE OF 1972, TO CONFORM WITH
56 THE PROVISIONS OF THIS ACT; TO BRING FORWARD SECTIONS 41-83-5,
57 41-83-7, 41-83-9, 41-83-11, 41-83-15, 41-83-17, 41-83-19,
58 41-83-23, 41-83-25, 41-83-27 AND 41-83-29, MISSISSIPPI CODE OF
59 1972, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED
60 PURPOSES.

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

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

64 **SECTION 2. Legislative findings.** The Mississippi
65 Legislature finds and declares that:

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

69 (b) Prior authorization programs may be subject to
70 member coverage agreements and medical policies, but shall not
71 hinder the independent medical judgment of a physician or other
72 health care provider; and



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

76 **SECTION 3. Applicability and scope.** This act applies to
77 every health insurance issuer and all health benefit plans, as
78 both terms are defined in Section 83-9-6.3, and all private review
79 agents and utilization review plans, as both terms are defined in
80 Section 41-83-1, with the exception of employee or employer
81 self-insured health benefit plans under the federal Employee
82 Retirement Income Security Act of 1974 or health care provided
83 pursuant to the Workers' Compensation Act. This act does not
84 diminish the duties and responsibilities under other federal or
85 state law or rules promulgated under those laws applicable to a
86 health insurer, health insurance issuer, health benefit plan,
87 private review agent or utilization review plan, including, but
88 not limited to, the requirement of a certificate in accordance
89 with Section 41-83-3.

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

93 (a) "Adverse determination" means a determination by a
94 health insurance issuer that, based on the information provided, a
95 request for a benefit under the health insurance issuer's health
96 benefit plan upon application of any utilization review technique
97 does not meet the health insurance issuer's requirements for



98 medical necessity, appropriateness, health care setting, level of
99 care, or effectiveness or is determined to be experimental or
100 investigational and the requested benefit is therefore denied,
101 reduced, or terminated or payment is not provided or made, in
102 whole or in part, for the benefit; the denial, reduction, or
103 termination of or failure to provide or make payment, in whole or
104 in part, for a benefit based on a determination by a health
105 insurance issuer that a preexisting condition was present before
106 the effective date of coverage; or a rescission of coverage
107 determination, which does not include a cancellation or
108 discontinuance of coverage that is attributable to a failure to
109 timely pay required premiums or contributions toward the cost of
110 coverage.

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

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

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

121 (e) "Department" means the Mississippi State Department
122 of Insurance.



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

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

132 (ii) Serious impairment to bodily functions; or

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

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

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

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

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



147 (k) "Health care service" means any services or level
148 of services included in the furnishing to an individual of medical
149 care or the hospitalization incident to the furnishing of such
150 care, as well as the furnishing to any person of any other
151 services for the purpose of preventing, alleviating, curing, or
152 healing human illness or injury, including behavioral health,
153 mental health, home health and pharmaceutical services and
154 products.

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

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

164 (i) In accordance with generally accepted
165 standards of medical practice; and

166 (ii) Clinically appropriate in terms of type,
167 frequency, extent, site and duration and are considered effective
168 for the patient's illness, injury or disease; and not primarily
169 for the convenience of the patient, treating physician, other
170 health care professional, caregiver, family member or other



171 interested party, but focused on what is best for the patient's
172 health outcome.

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

175 (o) "Prior authorization" means the process by which a
176 health insurance issuer determines the medical necessity and
177 medical appropriateness of an otherwise covered health care
178 service before the rendering of such health care service. "Prior
179 authorization" includes any health insurance issuer's requirement
180 that an enrollee, health care professional or health care provider
181 notify the health insurance issuer before, at the time of, or
182 concurrent to providing a health care service.

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

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

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

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



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

198 **SECTION 5. Disclosure and review of prior authorization**

199 **requirements.** (1) A health insurance issuer shall maintain a
200 complete list of services for which prior authorization is
201 required, including for all services where prior authorization is
202 performed by an entity under contract with the health insurance
203 issuer.

204 (2) A health insurance issuer shall make any current prior
205 authorization requirements and restrictions, including the written
206 clinical review criteria, readily accessible and conspicuously
207 posted on its website to enrollees, health care professionals and
208 health care providers. Content published by a third party and
209 licensed for use by a health insurance issuer may be made
210 available through the health insurance issuer's secure,
211 password-protected website so long as the access requirements of
212 the website do not unreasonably restrict access. Requirements
213 shall be described in detail, written in easily understandable
214 language, and readily available to the health care professional
215 and health care provider at the point of care. The website shall
216 indicate for each service subject to prior authorization:

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



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

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

226 (d) Where applicable, access to a standardized
227 electronic prior authorization request transaction process.

228 (3) The clinical review criteria must:

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

232 (b) Be developed in accordance with the current
233 standards of a national medical accreditation entity;

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

236 (d) Be evidence-based;

237 (e) Be sufficiently flexible to allow deviations from
238 norms when justified on a case-by-case basis; and

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

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



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

247 (a) An associated health care service has received
248 prior authorization; or

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

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

265 (7) Health insurance issuers using prior authorization shall
266 make statistics available regarding prior authorization approvals
267 and denials on their website in a readily accessible format.
268 Following each calendar year, the statistics must be updated



269 annually, by March 31, and include all of the following
270 information:

271 (a) A list of all health care services, including
272 medications, that are subject to prior authorization;

273 (b) The percentage of standard prior authorization
274 requests that were approved, aggregated for all items and
275 services;

276 (c) The percentage of standard prior authorization
277 requests that were denied, aggregated for all items and services;

278 (d) The percentage of prior authorization requests that
279 were approved after appeal, aggregated for all items and services;

280 (e) The percentage of prior authorization requests for
281 which the timeframe for review was extended, and the request was
282 approved, aggregated for all items and services;

283 (f) The percentage of expedited prior authorization
284 requests that were approved, aggregated for all items and
285 services;

286 (g) The percentage of expedited prior authorization
287 requests that were denied, aggregated for all items and services;

288 (h) The average and median time that elapsed between
289 the submission of a request and a determination by the payer, plan
290 or health insurance issuer, for standard prior authorization,
291 aggregated for all items and services;

292 (i) The average and median time that elapsed between
293 the submission of a request and a decision by the payer, plan or



294 health insurance issuer, for expedited prior authorizations,
295 aggregated for all items and services; and

296 (j) Any other information as the department determines
297 appropriate.

298 **SECTION 6. Standardized electronic prior authorizations.**

299 (1) If any health insurance issuer requires prior authorization
300 of a health care service, the insurer or its designee utilization
301 review organization shall, by January 1, 2025, make available a
302 standardized electronic prior authorization request transaction
303 process using an internet webpage, internet webpage portal, or
304 similar electronic, internet, and web-based system.

305 (2) Not later than January 1, 2027, all health care
306 professionals and health care providers shall be required to use
307 the standardized electronic prior authorization request
308 transaction process made available as required by subsection (1)
309 of this section.

310 **SECTION 7. Prior authorizations in nonurgent circumstances.**

311 If a health insurance issuer requires prior authorization of a
312 health care service, the health insurance issuer must make an
313 approval or adverse determination and notify the enrollee, the
314 enrollee's health care professional, and the enrollee's health
315 care provider of the approval or adverse determination as
316 expeditiously as the enrollee's condition requires but no later
317 than five (5) calendar days after obtaining all necessary
318 information to make the approval or adverse determination, unless



319 a longer minimum time frame is required under federal law for the
320 health insurance issuer and the health care service at issue. As
321 used in this section, "necessary information" includes the results
322 of any face-to-face clinical evaluation, second opinion or other
323 clinical information that is directly applicable to the requested
324 service that may be required. Notwithstanding the foregoing
325 provisions of this section, health insurance issuers must comply
326 with the requirements of Section 83-9-6.3 to respond by two (2)
327 business days for prior authorization requests for pharmaceutical
328 services and products.

329 **SECTION 8. Prior authorizations in urgent circumstances.**

330 (1) If requested by a treating health care provider or health
331 care professional for an enrollee, a health insurance issuer must
332 render an approval or adverse determination concerning urgent
333 health care services and notify the enrollee, the enrollee's
334 health care professional and the enrollee's health care provider
335 of that approval or adverse determination as expeditiously as the
336 enrollee's condition requires but no later than twenty-four (24)
337 hours after receiving all information needed to complete the
338 review of the requested health care services, unless a longer
339 minimum time frame is required under federal law for the health
340 insurance issuer and the urgent health care service at issue.

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



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

348 **SECTION 9. Personnel qualified to make adverse**

349 **determinations.** (1) A health insurance issuer must ensure that
350 all adverse determinations are made by a physician when the
351 request is by a physician or a representative of a physician. The
352 physician must:

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

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

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

363 **SECTION 10. Notifications for adverse determinations.** If a
364 health insurance issuer makes an adverse determination, the health
365 insurance issuer shall include the following in the notification
366 to the enrollee, the enrollee's health care professional, and the
367 enrollee's health care provider:



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

371 (b) The right to appeal the adverse determination;

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

373 (d) Additional documentation necessary to support the
374 appeal.

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

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

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

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

387 (d) Not have been directly involved in making the
388 adverse determination; and

389 (e) Consider all known clinical aspects of the health
390 care service under review, including, but not limited to, a review
391 of all pertinent medical records provided to the health insurance
392 issuer by the enrollee's health care professional or health care



393 provider and any medical literature provided to the health
394 insurance issuer by the health care professional or health care
395 provider.

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

400 **SECTION 12. Insurer review of prior authorization**

401 **requirements.** A health insurance issuer shall periodically review
402 its prior authorization requirements and consider removal of prior
403 authorization requirements:

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

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

410 **SECTION 13. Revocation of prior authorizations.** (1) A

411 health insurance issuer may not revoke or further limit, condition
412 or restrict a previously issued prior authorization approval while
413 it remains valid under this act.

414 (2) Notwithstanding any other provision of law, if a claim
415 is properly coded and submitted timely to a health insurance
416 issuer, the health insurance issuer shall make payment according
417 to the terms of coverage on claims for health care services for



418 which prior authorization was required and approval received
419 before the rendering of health care services, unless one (1) of
420 the following occurs:

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

427 (b) It is timely determined that the health care
428 services claimed were not performed;

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

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

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



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

446 **SECTION 14. Length of approvals.** (1) A prior authorization
447 approval shall be valid for the lesser of six (6) months after the
448 date the health care professional or health care provider receives
449 the prior authorization approval or the length of treatment as
450 determined by the patient's health care professional or the
451 renewal of the policy or plan, and the approval period shall be
452 effective regardless of any changes, including any changes in
453 dosage for a prescription drug prescribed by the health care
454 professional. Notwithstanding the foregoing, a health insurer and
455 an enrollee or his/her health care professional may extend a prior
456 authorization approval for a longer period, by agreement. All
457 dosage increases must be based on established evidentiary
458 standards, and nothing in this section shall prohibit a health
459 insurance issuer from having safety edits in place. This section
460 shall not apply to the prescription of benzodiazepines or Schedule
461 II narcotic drugs, such as opioids.

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



467 **SECTION 15. Approvals for chronic conditions.** (1) If a
468 health insurance issuer requires a prior authorization for a
469 recurring health care service or maintenance medication for the
470 treatment of a chronic or long-term condition, including, but not
471 limited to, chemotherapy for the treatment of cancer, the approval
472 shall remain valid for the lesser of twelve (12) months from the
473 date the health care professional or health care provider receives
474 the prior authorization approval or the length of the treatment as
475 determined by the patient's health care professional.
476 Notwithstanding the foregoing, a health insurer and an enrollee or
477 his or her health care professional may extend a prior
478 authorization approval for a longer period, by agreement. This
479 section shall not apply to the prescription of benzodiazepines or
480 Schedule II narcotic drugs, such as opioids.

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

486 **SECTION 16. Continuity of prior approvals.** (1) On receipt
487 of information documenting a prior authorization approval from the
488 enrollee or from the enrollee's health care professional or health
489 care provider, a health insurance issuer shall honor a prior
490 authorization granted to an enrollee from a previous health
491 insurance issuer for at least the initial ninety (90) days of an



492 enrollee's coverage under a new health plan, subject to the terms
493 of the member's coverage agreement.

494 (2) During the time period described in subsection (1) of
495 this section, a health insurance issuer may perform its own review
496 to grant a prior authorization approval subject to the terms of
497 the member's coverage agreement.

498 (3) If there is a change in coverage of or approval criteria
499 for a previously authorized health care service, the change in
500 coverage or approval criteria does not affect an enrollee who
501 received prior authorization approval before the effective date of
502 the change for the remainder of the enrollee's plan year.

503 (4) Except to the extent required by medical exceptions
504 processes for prescription drugs, nothing in this section shall
505 require a policy or plan to cover any care, treatment or services
506 for any health condition that the terms of coverage otherwise
507 completely exclude from the policy's or plan's covered benefits
508 without regard for whether the care, treatment or services are
509 medically necessary.

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



516 **SECTION 18. Enforcement and administration.** (1) In
517 addition to the enforcement powers granted to it by law to enforce
518 the provisions of this act, the department is granted specific
519 authority to issue a cease-and-desist order or require a private
520 review agent or health insurance issuer to submit a plan of
521 correction for violations of this act, or both. Subject to
522 regulations promulgated by the department under the provisions of
523 the Mississippi Administrative Procedure Law and after proper
524 notice and the opportunity for a hearing, the department may
525 impose upon a private review agent, health benefit plan or health
526 insurance issuer an administrative fine not to exceed Ten Thousand
527 Dollars (\$10,000.00) per violation for failure to submit a
528 requested plan of correction, failure to comply with its plan of
529 correction, or repeated violations of this act. All fines
530 collected by the department under this section shall be deposited
531 into the State General Fund. The department may also exercise all
532 authority granted to it under Section 41-83-13 to deny or revoke a
533 certificate of a private review agent for a violation of this act.

534 (2) Any person or his or her treating physician who has
535 evidence that his or her health insurance issuer or health benefit
536 plan is in violation of the provisions of this act may file a
537 complaint with the department. The department shall review all
538 complaints received and investigate all complaints that it deems
539 to state a potential violation. The department shall fairly,
540 efficiently and timely review and investigate complaints. Health



541 insurance issuers, health benefit plans and private review agents
542 found to be in violation of this act shall be penalized in
543 accordance with this section.

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

547 **SECTION 19. Reports to the department.** (1) By June 1,
548 2025, and each June 1 after that date, a health insurance issuer
549 shall report to the department, on a form issued by the
550 department, the following aggregated trend data, de-identified of
551 protected health information, related to the insurer's practices
552 and experience for the prior plan year for health care services
553 submitted for payment:

554 (a) The number of prior authorization requests;

555 (b) The number of prior authorization requests denied;

556 (c) The number of prior authorization appeals received;

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

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

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

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



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

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

570 (j) The ten (10) health care services that were most
571 frequently denied as a result of post-service utilization reviews.

572 (2) All reports required by this section shall be considered
573 public records under the Mississippi Public Records Act of 1983
574 and the department shall make all reports freely available to
575 requestors and post all reports to its public website without
576 redactions.

577 **SECTION 20. False requests for prior authorization.** If a
578 health insurance issuer has clear and convincing evidence that a
579 health care professional or health care provider has knowingly and
580 willingly submitted false or fraudulent requests for prior
581 authorization to the health insurance issuer, the issuer shall
582 notify and provide that information to the Commissioner of
583 Insurance. After receipt of such notification and information,
584 the commissioner shall forward these reports to the Board of
585 Medical Licensure or such other licensing agency with oversight of
586 the health care provider.

587 **SECTION 21.** Section 41-83-1, Mississippi Code of 1972, is
588 amended as follows:

589 41-83-1. As used in this chapter, the following terms shall
590 be defined as follows:



591 (a) "Utilization review" means a system for reviewing
592 the appropriate and efficient allocation of hospital resources and
593 medical services given or proposed to be given, including, but not
594 limited to, any prior authorization as defined in Section 4 of
595 this act, to a patient or group of patients as to necessity for
596 the purpose of determining whether such service should be covered
597 or provided by an insurer, plan or other entity.

598 (b) "Private review agent" means a
599 nonhospital-affiliated person or entity performing utilization
600 review on behalf of:

601 (i) An employer or employees in the State of
602 Mississippi; or

603 (ii) A third party that provides or administers
604 hospital and medical benefits to citizens of this state,
605 including: a health maintenance organization issued a certificate
606 of authority under and by virtue of the laws of the State of
607 Mississippi; or a health insurer, nonprofit health service plan,
608 health insurance service organization, or preferred provider
609 organization or other entity offering health insurance policies,
610 contracts or benefits in this state.

611 (c) "Utilization review plan" means a description of
612 the utilization review procedures of a private review agent.

613 (d) "Department" means the Mississippi State Department
614 of * * * Insurance.



615 (e) "Certificate" means a certificate of registration
616 granted by the Mississippi State Department of * * * Insurance to
617 a private review agent.

618 **SECTION 22.** Section 41-83-3, Mississippi Code of 1972, is
619 amended as follows:

620 41-83-3. (1) A private review agent who approves or denies
621 payment or who recommends approval or denial of payment for
622 hospital or medical services or whose review results in approval
623 or denial of payment for hospital or medical services on a case by
624 case basis, may not conduct utilization review in this state
625 unless the Mississippi State Department of * * * Insurance has
626 granted the private review agent a certificate.

627 (2) The Mississippi State Department of * * * Insurance
628 shall issue a certificate to an applicant that has met all the
629 requirements of this chapter and all applicable regulations of the
630 department.

631 (3) A certificate issued under this chapter is not
632 transferable.

633 (4) The State Department of * * * Insurance shall adopt
634 regulations to implement the provisions of this chapter. Any
635 personal information required by the department with respect to
636 customers or patients shall be held in confidence and not
637 disclosed to the public.

638 **SECTION 23.** Section 41-83-13, Mississippi Code of 1972, is
639 amended as follows:



640 41-83-13. (1) The department shall deny a certificate to
641 any applicant if, upon review of the application, the department
642 finds that the applicant proposing to conduct utilization review
643 does not:

644 (a) Have available the services of a physician to carry
645 out its utilization review activities;

646 (b) Meet any applicable regulations the department
647 adopted under this chapter relating to the qualifications of
648 private review agents or the performance of utilization review;
649 and

650 (c) Provide assurances satisfactory to the department
651 that the procedure and policies of the private review agent will
652 protect the confidentiality of medical records and the private
653 review agent will be reasonably accessible to patients and
654 providers for five (5) working days a week during normal business
655 hours in this state.

656 (2) The department may revoke or deny a certificate if the
657 holder does not comply with the performance assurances under this
658 section, violates any provision of this chapter, or violates any
659 regulation adopted pursuant to this chapter.

660 (3) Before denying or revoking a certificate under this
661 section, the department shall provide the applicant or certificate
662 holder with reasonable time to supply additional information
663 demonstrating compliance with the requirements of this chapter and
664 the opportunity to request a hearing. If an applicant or



665 certificate holder requests a hearing, the department shall send a
666 hearing notice and conduct a hearing * * *.

667 **SECTION 24.** Section 41-83-31, Mississippi Code of 1972, is
668 amended as follows:

669 41-83-31. Any program of utilization review with regard to
670 hospital, medical or other health care services provided in this
671 state, including, but not limited to, any prior authorization as
672 defined in Section 4 of this act, shall comply with the following:

673 (a) No determination adverse to a patient or to any
674 affected health care provider shall be made on any question
675 relating to the necessity or justification for any form of
676 hospital, medical or other health care services without prior
677 evaluation and concurrence in the adverse determination by a
678 physician licensed to practice in * * * any United States
679 jurisdiction and certified by the board(s) of the American Board
680 of Medical Specialists or the American Board of Osteopathy within
681 the relevant specialty. The physician who made the adverse
682 determination shall discuss the reasons for any adverse
683 determination with the affected health care provider, if the
684 provider so requests. The physician shall comply with this
685 request within * * * seven (7) calendar days of being notified of
686 a request. Adverse determination by a physician shall not be
687 grounds for any disciplinary action against the physician by the
688 State Board of Medical Licensure.



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

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

707 **SECTION 25.** Section 83-1-101, Mississippi Code of 1972, is
708 amended as follows:

709 83-1-101. Notwithstanding any other provision of law to the
710 contrary, and except as provided herein, any person or other
711 entity which provides coverage in this state for medical,
712 surgical, chiropractic, physical therapy, speech pathology,
713 audiology, professional mental health, dental, hospital, or



714 optometric expenses, whether such coverage is by direct payment,
715 reimbursement * * * or otherwise, and all private review agents
716 covered by Sections 41-83-1 through 41-83-31, shall be presumed to
717 be subject to the jurisdiction of the State Insurance Department,
718 unless (a) the person or other entity shows that while providing
719 such services it is subject to the jurisdiction of another agency
720 of this state, any subdivisions thereof, or the federal
721 government; or (b) the person or other entity is providing
722 coverage under the Direct Primary Care Act in Sections 83-81-1
723 through 83-81-11.

724 **SECTION 26.** Section 41-83-21, Mississippi Code of 1972, is
725 amended as follows:

726 41-83-21. Notwithstanding language to the contrary elsewhere
727 contained herein, if a licensed physician certifies in writing to
728 an insurer within seventy-two (72) hours of an admission that the
729 insured person admitted was in need of immediate hospital care for
730 emergency services, such shall constitute a prima facie case of
731 the medical necessity of the admission. To overcome this, the
732 entity requesting the utilization review and/or the private review
733 agent must show by clear and convincing evidence that the admitted
734 person was not in need of immediate hospital care.

735 **SECTION 27.** Section 83-9-6.3, Mississippi Code of 1972, is
736 amended as follows:

737 83-9-6.3. (1) As used in this section:



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

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

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



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

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

783 (3) A health insurance issuer shall respond within two (2)
784 business days upon receipt of a completed prior authorization
785 request from a prescribing provider that was submitted using the
786 standardized prior authorization form required by subsection (2)
787 of this section. Notwithstanding the foregoing provisions of this



788 subsection, health insurance issuers shall comply with Section 8
789 of this act in regard to prior authorizations in urgent
790 circumstances.

791 **SECTION 28.** Section 41-83-5, Mississippi Code of 1972, is
792 brought forward as follows:

793 41-83-5. No certificate is required for those private review
794 agents conducting general in-house utilization review for
795 hospitals, home health agencies, preferred provider organizations
796 or other managed care entities, clinics, private physician offices
797 or any other health facility or entity, so long as the review does
798 not result in the approval or denial of payment for hospital or
799 medical services for a particular case. Such general in-house
800 utilization review is completely exempt from the provisions of
801 this chapter.

802 **SECTION 29.** Section 41-83-7, Mississippi Code of 1972, is
803 brought forward as follows:

804 41-83-7. (1) An applicant for a certificate shall:

805 (a) Submit an application to the department; and

806 (b) Pay to the department the application fee

807 established by the department through regulation.

808 (2) The application shall:

809 (a) Be on a form and accompanied by any supporting
810 documentation that the department requires; and

811 (b) Be signed and verified by the applicant.



812 (3) The application fee required under this section shall be
813 sufficient to pay for the administrative cost of the certification
814 program and any other cost associated with carrying out the
815 provisions of this chapter.

816 **SECTION 30.** Section 41-83-9, Mississippi Code of 1972, is
817 brought forward as follows:

818 41-83-9. In conjunction with the application, the private
819 review agent shall submit information that the department requires
820 including:

821 (a) A utilization review plan that includes a
822 description of review criteria, standards and procedures to be
823 used in evaluating proposed or delivered hospital and medical care
824 and the provisions by which patients, physicians or hospitals may
825 seek reconsideration or appeal of adverse decisions by the private
826 review agent;

827 (b) The type and qualifications of the personnel either
828 employed or under contract to perform the utilization review;

829 (c) The procedures and policies to insure that a
830 representative of the private review agent is reasonably
831 accessible to patients and providers at all times in this state;

832 (d) The policies and procedures to insure that all
833 applicable state and federal laws to protect the confidentiality
834 of individual medical records are followed;



835 (e) A copy of the materials designed to inform
836 applicable patients and providers of the requirements of the
837 utilization review plan; and

838 (f) A list of the third party payors for which the
839 private review agent is performing utilization review in this
840 state.

841 **SECTION 31.** Section 41-83-11, Mississippi Code of 1972, is
842 brought forward as follows:

843 41-83-11. (1) A certificate expires on the second
844 anniversary of its effective date unless the certificate is
845 renewed for a two-year term as provided in this section.

846 (2) Before the certificate expires, a certificate may be
847 renewed for an additional two-year term if the applicant:

848 (a) Otherwise is entitled to the certificate;

849 (b) Pays the department the renewal fee set by the
850 department through regulation; and

851 (c) Submits to the department a renewal application on
852 the form that the department requires and satisfactory evidence of
853 compliance with any requirement of this chapter for certificate
854 renewal.

855 **SECTION 32.** Section 41-83-15, Mississippi Code of 1972, is
856 brought forward as follows:

857 41-83-15. The department shall establish reporting
858 requirements to:



859 (a) Evaluate the effectiveness of private review
860 agents; and

861 (b) Determine if the utilization review programs are in
862 compliance with the provisions of this section and applicable
863 regulations.

864 **SECTION 33.** Section 41-83-17, Mississippi Code of 1972, is
865 brought forward as follows:

866 41-83-17. A private review agent may not disclose or publish
867 individual medical records or any other confidential medical
868 information obtained in the performance of utilization review
869 activities without the patient's authorization or an order of a
870 county, circuit or chancery court of Mississippi or a United
871 States district court. Provided, however, that nothing in this
872 chapter shall prohibit private review agents from providing
873 information to a third party with whom the private review agent is
874 under contract or acting on behalf of.

875 **SECTION 34.** Section 41-83-19, Mississippi Code of 1972, is
876 brought forward as follows:

877 41-83-19. A person who violates any provision of this
878 chapter or any regulation adopted under this chapter is guilty of
879 a misdemeanor and on conviction is subject to a penalty not
880 exceeding One Thousand Dollars (\$1,000.00).

881 **SECTION 35.** Section 41-83-23, Mississippi Code of 1972, is
882 brought forward as follows:



883 41-83-23. Any person aggrieved by a final decision of the
884 department or a private review agent in a contested case under
885 this chapter shall have the right of judicial appeal to the
886 chancery court of the county of the residence of the aggrieved
887 person.

888 Notwithstanding any provision of this chapter, the insured
889 shall have the express right to pursue any legal remedies he may
890 have in a court of competent jurisdiction.

891 **SECTION 36.** Section 41-83-25, Mississippi Code of 1972, is
892 brought forward as follows:

893 41-83-25. (1) Every health insurance plan proposing to
894 issue or deliver a health insurance policy or contract or
895 administer a health benefit program which provides for the
896 coverage of hospital and medical benefits and the utilization
897 review of those benefits shall:

898 (a) Have a certificate in accordance with this chapter;
899 or

900 (b) Contract with a private review agent who has a
901 certificate in accordance with this chapter.

902 (2) Notwithstanding any other provisions of this chapter,
903 for claims where the medical necessity of the provision of a
904 covered benefit is disputed, a health service plan that does not
905 meet the requirements of subsection (1) of this section shall pay
906 any person or hospital entitled to reimbursement under the policy
907 or contract.



908 **SECTION 37.** Section 41-83-27, Mississippi Code of 1972, is
909 brought forward as follows:

910 41-83-27. (1) Every insurer proposing to issue or deliver a
911 health insurance policy or contract or administer a health benefit
912 program which provides for the coverage of hospital and medical
913 benefits and the utilization review of such benefits shall:

914 (a) Have a certificate in accordance with this chapter;
915 or

916 (b) Contract with a private review agent that has a
917 certificate in accordance with this chapter.

918 (2) Notwithstanding any provision of this chapter, for
919 claims where the medical necessity of the provision of a covered
920 benefit is disputed, an insurer that does not meet the
921 requirements of subsection (1) of this section shall pay any
922 person or hospital entitled to reimbursement under the policy or
923 contract.

924 **SECTION 38.** Section 41-83-29, Mississippi Code of 1972, is
925 brought forward as follows:

926 41-83-29. Any health insurer proposing to issue or deliver
927 in this state a group or blanket health insurance policy or
928 administer a health benefit program which provides for the
929 coverage of hospital and medical benefits and the utilization
930 review of such benefits shall:

931 (a) Have a certificate in accordance with this chapter;
932 or



933 (b) Contract with a private review agent that has a
934 certificate in accordance with this chapter.

935 **SECTION 39.** This act shall take effect and be in force from
936 and after July 1, 2024.

