Tabled
AMENDMENT NO 1 PROPOSED TO

Senate Bill No. 2140

BY: Committee

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

60 **SECTION 1.** This act shall be known and may be cited as the
61 "Mississippi Prior Authorization Reform Act."
62 **SECTION 2.** **Legislative findings.** The Mississippi
63 Legislature finds and declares that:
64 (a) The health care professional-patient relationship
65 is paramount and should not be subject to unreasonable third-party
66 interference;
67 (b) Prior authorization programs may be subject to
68 member coverage agreements and medical policies, but shall not

69 hinder the independent medical judgment of a physician or other
70 health care provider; and

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

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

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

91 (a) "Adverse determination" means a determination by a
92 health insurance issuer that, based on the information provided, a
93 request for a benefit under the health insurance issuer's health

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

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

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

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

119 (e) "Department" means the Mississippi State Department
120 of Insurance.
121 (f) "Emergency medical condition" means a medical
122 condition manifesting itself by acute symptoms of sufficient
123 severity, including, but not limited to, severe pain, such that a
124 prudent layperson who possesses an average knowledge of health and
125 medicine could reasonably expect the absence of immediate medical
126 attention to result in:
127 (i) Placing the health of the individual or, with
128 respect to a pregnant woman, the health of the woman or her unborn
129 child, in serious jeopardy;
130 (ii) Serious impairment to bodily functions; or
131 (iii) Serious dysfunction of any bodily organ or
132 part.
133 (g) "Emergency services" means health care items and
134 services furnished or required to evaluate and treat an emergency
135 medical condition.
136 (h) "Enrollee" means any person and his or her
137 dependents enrolled in or covered by a health care plan.
138 (i) "Health care professional" means a physician, a
139 registered professional nurse or other individual appropriately
140 licensed or registered to provide health care services.
141 (j) "Health care provider" means any physician,
142 hospital, ambulatory surgery center, or other person or facility

143 that is licensed or otherwise authorized to deliver health care
144 services.
145 (k) "Health care service" means any services or level
146 of services included in the furnishing to an individual of medical
147 care or the hospitalization incident to the furnishing of such
148 care, as well as the furnishing to any person of any other
149 services for the purpose of preventing, alleviating, curing, or
150 healing human illness or injury, including behavioral health,
151 mental health, home health and pharmaceutical services and
152 products.
153 (l) "Health insurance issuer" has the meaning given to
154 that term in Section 83-9-6.3. Any provision of this act that
155 applies to a "health insurance issuer" also applies to any person
156 or entity covered under the scope of this act in Section 3 of this
157 act.
158 (m) "Medically necessary" means a health care
159 professional exercising prudent clinical judgment would provide
160 care to a patient for the purpose of preventing, diagnosing, or
161 treating an illness, injury, disease or its symptoms and that are:
162 (i) In accordance with generally accepted
163 standards of medical practice; and
164 (ii) Clinically appropriate in terms of type,
165 frequency, extent, site and duration and are considered effective
166 for the patient's illness, injury or disease; and not primarily
167 for the convenience of the patient, treating physician, other

168 health care professional, caregiver, family member or other
169 interested party, but focused on what is best for the patient's
170 health outcome.

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

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

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

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

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

192 (iii) Could lead to likely onset of an emergency
193 medical condition if the service is not rendered during the time
194 period to render a prior authorization determination for an urgent
195 medical service.

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

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

200 **SECTION 5.** **Disclosure and review of prior authorization**
201 **requirements.** (1) A health insurance issuer shall maintain a
202 complete list of services for which prior authorization is
203 required, including for all services where prior authorization is
204 performed by an entity under contract with the health insurance
205 issuer.

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

217 and health care provider at the point of care. The website shall
218 indicate for each service subject to prior authorization:
219 (a) When prior authorization became required for
220 policies issued or health benefit plan documents delivered in
221 Mississippi, including the effective date or dates and the
222 termination date or dates, if applicable, in Mississippi;
223 (b) The date the Mississippi-specific requirement was
224 listed on the health insurance issuer's, health benefit plan's, or
225 private review agent's website;
226 (c) Where applicable, the date that prior authorization
227 was removed for Mississippi; and
228 (d) Where applicable, access to a standardized
229 electronic prior authorization request transaction process.
230 (3) The clinical review criteria must:
231 (a) Be based on nationally recognized, generally
232 accepted standards except where state law provides its own
233 standard;
234 (b) Be developed in accordance with the current
235 standards of a national medical accreditation entity;
236 (c) Ensure quality of care and access to needed health
237 care services;
238 (d) Be evidence-based;
239 (e) Be sufficiently flexible to allow deviations from
240 norms when justified on a case-by-case basis; and

241 (f) Be evaluated and updated, if necessary, at least
242 annually.
243 (4) A health insurance issuer shall not deny a claim for
244 failure to obtain prior authorization if the prior authorization
245 requirement was not in effect on the date of service on the claim.
246 (5) A health insurance issuer shall not deem as incidental
247 or deny supplies or health care services that are routinely used
248 as part of a health care service when:
249 (a) An associated health care service has received
250 prior authorization; or
251 (b) Prior authorization for the health care service is
252 not required.
253 (6) If a health insurance issuer intends either to implement
254 a new prior authorization requirement or restriction or amend an
255 existing requirement or restriction, the health insurance issuer
256 shall provide contracted health care professionals and contracted
257 health care providers of enrollees written notice of the new or
258 amended requirement or amendment no less than sixty (60) days
259 before the requirement or restriction is implemented. Written
260 notice may take the form of a conspicuous notice posted on the
261 health insurance issuer's public website or portal for contracted
262 health care professionals and contracted health care providers. A
263 health insurance issuer shall provide email notices to health care
264 professionals or health care providers if the health care
265 professional or health care provider has requested to receive the

266 notice through email. The health insurance issuer shall ensure
267 that the new or amended requirement is not implemented unless the
268 health insurance issuer's website has been updated to reflect the
269 new or amended requirement or restriction. Written notice of a
270 new, amended, or restricted prior authorization requirement, as
271 required by this subsection (6), may be provided less than sixty
272 (60) days in advance if a health insurance issuer determines and
273 contemporaneously notifies the department in writing that:
274 (a) The health insurance issuer has identified
275 fraudulent or abusive practices related to the health care
276 service;
277 (b) The health care service is unavailable or scarce
278 which necessitates the use of an alternative health care service;
279 (c) The health care service is newly introduced to the
280 health care market and a delay in providing coverage for the
281 health care service and would not be in the best interests of
282 enrollees;
283 (d) The health care service is the subject of a
284 clinical trial authorized by the United States Food and Drug
285 Administration; or
286 (e) Changes to the health care service or its
287 availability are otherwise required by law to be made by the
288 health insurance issuer in less than sixty (60) days.
289 (7) Health insurance issuers using prior authorization shall
290 make statistics available regarding prior authorization approvals

291 and denials on their website in a readily accessible format.
292 Following each calendar year, the statistics must be updated
293 annually, by March 31, and include all of the following
294 information:
295 (a) A list of all health care services, including
296 medications, that are subject to prior authorization;
297 (b) The percentage of standard prior authorization
298 requests that were approved, aggregated for all items and
299 services;
300 (c) The percentage of standard prior authorization
301 requests that were denied, aggregated for all items and services;
302 (d) The percentage of prior authorization requests that
303 were approved after appeal, aggregated for all items and services;
304 (e) The percentage of prior authorization requests for
305 which the timeframe for review was extended, and the request was
306 approved, aggregated for all items and services;
307 (f) The percentage of expedited prior authorization
308 requests that were approved, aggregated for all items and
309 services;
310 (g) The percentage of expedited prior authorization
311 requests that were denied, aggregated for all items and services;
312 (h) The average and median time that elapsed between
313 the submission of a request and a determination by the payer, plan
314 or health insurance issuer, for standard prior authorization,
315 aggregated for all items and services;

316 (i) The average and median time that elapsed between
317 the submission of a request and a decision by the payer, plan or
318 health insurance issuer, for expedited prior authorizations,
319 aggregated for all items and services; and
320 (j) Any other information as the department determines
321 appropriate.
322 **SECTION 6. Standardized electronic prior authorizations.**
323 (1) If any health insurance issuer requires prior authorization
324 of a health care service, the insurer or its designee utilization
325 review organization shall, by January 1, 2025, make available a
326 standardized electronic prior authorization request transaction
327 process using an Internet webpage, Internet webpage portal, or
328 similar electronic, Internet, and web-based system.
329 (2) Not later than January 1, 2027, all health care
330 professionals and health care providers shall be required to use
331 the standardized electronic prior authorization request
332 transaction process made available as required by subsection (1)
333 of this section.
334 **SECTION 7. Prior authorizations in nonurgent circumstances.**
335 If a health insurance issuer requires prior authorization of a
336 health care service, the health insurance issuer must make an
337 approval or adverse determination and notify the enrollee, the
338 enrollee's health care professional, and the enrollee's health
339 care provider of the approval or adverse determination as
340 expeditiously as the enrollee's condition requires but no later

341 than seven (7) calendar days after obtaining all necessary
342 information to make the approval or adverse determination, unless
343 a longer minimum time frame is required under federal law for the
344 health insurance issuer and the health care service at issue. As
345 used in this section, "necessary information" includes the results
346 of any face-to-face clinical evaluation, second opinion or other
347 clinical information that is directly applicable to the requested
348 service that may be required. Notwithstanding the foregoing
349 provisions of this section, health insurance issuers must comply
350 with the requirements of Section 83-9-6.3 to respond by two (2)
351 business days for prior authorization requests for pharmaceutical
352 services and products.

353 **SECTION 8. Prior authorizations in urgent circumstances.**
354 (1) If requested by a treating health care provider or health
355 care professional for an enrollee, a health insurance issuer must
356 render an approval or adverse determination concerning urgent
357 health care services and notify the enrollee, the enrollee's
358 health care professional and the enrollee's health care provider
359 of that approval or adverse determination as expeditiously as the
360 enrollee's condition requires but no later than forty-eight (48)
361 hours after receiving all information needed to complete the
362 review of the requested health care services, unless a longer
363 minimum time frame is required under federal law for the health
364 insurance issuer and the urgent health care service at issue.

365 (2) To facilitate the rendering of a prior authorization
366 determination in conformance with this section, a health insurance
367 issuer must establish a mechanism to ensure health care
368 professionals have access to appropriately trained and licensed
369 clinical personnel who have access to physicians for consultation,
370 designated by the plan to make such determinations for prior
371 authorization concerning urgent care services.

372 **SECTION 9.** **Notifications for adverse determinations.** If a
373 health insurance issuer makes an adverse determination, the health
374 insurance issuer shall include the following in the notification
375 to the enrollee, the enrollee's health care professional, and the
376 enrollee's health care provider:

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

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

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

382 (d) Additional documentation necessary to support the
383 appeal.

384 **SECTION 10.** **Personnel qualified to review appeals.** (1) A
385 health insurance issuer must ensure that all appeals are reviewed
386 by a physician when the request is by a physician or a
387 representative of a physician. The physician must:

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

390 (b) Be certified by the board(s) of the American Board
391 of Medical Specialists or the American Board of Osteopathy within
392 the relevant specialty of a physician who typically manages the
393 medical condition or disease;
394 (c) Be knowledgeable of, and have experience providing,
395 the health care services under appeal;
396 (d) Not have been directly involved in making the
397 adverse determination; and
398 (e) Consider all known clinical aspects of the health
399 care service under review, including, but not limited to, a review
400 of all pertinent medical records provided to the health insurance
401 issuer by the enrollee's health care professional or health care
402 provider and any medical literature provided to the health
403 insurance issuer by the health care professional or health care
404 provider.
405 (2) Notwithstanding the foregoing, a licensed health care
406 professional who satisfies the requirements in this section may
407 review appeal requests submitted by a health care professional
408 licensed in the same profession.
409 **SECTION 11. Insurer review of prior authorization**
410 **requirements.** A health insurance issuer shall periodically review
411 its prior authorization requirements and consider removal of prior
412 authorization requirements:
413 (a) Where a medication or procedure prescribed is
414 customary and properly indicated or is a treatment for the

415 clinical indication as supported by peer-reviewed medical
416 publications; or
417 (b) For patients currently managed with an established
418 treatment regimen.
419 **SECTION 12.** **Revocation of prior authorizations.** (1) A
420 health insurance issuer may not revoke or further limit, condition
421 or restrict a previously issued prior authorization approval while
422 it remains valid under this act.
423 (2) Notwithstanding any other provision of law, if a claim
424 is properly coded and submitted timely to a health insurance
425 issuer, the health insurance issuer shall make payment according
426 to the terms of coverage on claims for health care services for
427 which prior authorization was required and approval received
428 before the rendering of health care services, unless one (1) of
429 the following occurs:
430 (a) It is timely determined that the enrollee's health
431 care professional or health care provider knowingly and without
432 exercising prudent clinical judgment provided health care services
433 that required prior authorization from the health insurance issuer
434 or its contracted private review agent without first obtaining
435 prior authorization for those health care services;
436 (b) It is timely determined that the health care
437 services claimed were not performed;
438 (c) It is timely determined that the health care
439 services rendered were contrary to the instructions of the health

440 insurance issuer or its contracted private review agent or
441 delegated reviewer if contact was made between those parties
442 before the service being rendered;
443 (d) It is timely determined that the enrollee receiving
444 such health care services was not an enrollee of the health care
445 plan; or
446 (e) The approval was based upon a material
447 misrepresentation by the enrollee, health care professional, or
448 health care provider; as used in this paragraph, "material" means
449 a fact or situation that is not merely technical in nature and
450 results or could result in a substantial change in the situation.
451 (3) Nothing in this section shall preclude a private review
452 agent or a health insurance issuer from performing post-service
453 reviews of health care claims for purposes of payment integrity or
454 for the prevention of fraud, waste, or abuse.
455 **SECTION 13.** **Length of approvals.** (1) A prior authorization
456 approval shall be valid for the lesser of six (6) months after the
457 date the health care professional or health care provider receives
458 the prior authorization approval or the length of treatment as
459 determined by the patient's health care professional or the
460 renewal of the policy or plan, and the approval period shall be
461 effective regardless of any changes, including any changes in
462 dosage for a prescription drug prescribed by the health care
463 professional. Notwithstanding the foregoing, a health insurer and
464 an enrollee or his/her health care professional may extend a prior

465 authorization approval for a longer period, by agreement. All
466 dosage increases must be based on established evidentiary
467 standards, and nothing in this section shall prohibit a health
468 insurance issuer from having safety edits in place. This section
469 shall not apply to the prescription of benzodiazepines or Schedule
470 II narcotic drugs, such as opioids.

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

476 **SECTION 14.** **Approvals for chronic conditions.** (1) If a
477 health insurance issuer requires a prior authorization for a
478 recurring health care service or maintenance medication for the
479 treatment of a chronic or long-term condition, including, but not
480 limited to, chemotherapy for the treatment of cancer, the approval
481 shall remain valid for the lesser of twelve (12) months from the
482 date the health care professional or health care provider receives
483 the prior authorization approval or the length of the treatment as
484 determined by the patient's health care professional.
485 Notwithstanding the foregoing, a health insurer and an enrollee or
486 his or her health care professional may extend a prior
487 authorization approval for a longer period, by agreement. This
488 section shall not apply to the prescription of benzodiazepines or
489 Schedule II narcotic drugs, such as opioids.

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

495 **SECTION 15.** **Continuity of prior approvals.** (1) On receipt
496 of information documenting a prior authorization approval from the
497 enrollee or from the enrollee's health care professional or health
498 care provider, a health insurance issuer shall honor a prior
499 authorization granted to an enrollee from a previous health
500 insurance issuer for at least the initial ninety (90) days of an
501 enrollee's coverage under a new health plan, subject to the terms
502 of the member's coverage agreement.

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

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

512 (4) Except to the extent required by medical exceptions
513 processes for prescription drugs, nothing in this section shall
514 require a policy or plan to cover any care, treatment or services

515 for any health condition that the terms of coverage otherwise
516 completely exclude from the policy's or plan's covered benefits
517 without regard for whether the care, treatment or services are
518 medically necessary.

519 **SECTION 16.** **Effect of insurer's failure to comply.** A
520 failure by a health insurance issuer to comply with the deadlines
521 and other requirements specified in this act shall result in any
522 health care services subject to review to be automatically deemed
523 authorized by the health insurance issuer or its contracted
524 private review agent.

525 **SECTION 17.** **Enforcement and administration.** (1) In
526 addition to the enforcement powers granted to it by law to enforce
527 the provisions of this act, the department is granted specific
528 authority to issue a cease-and-desist order or require a private
529 review agent or health insurance issuer to submit a plan of
530 correction for violations of this act, or both. Subject to
531 regulations promulgated by the department under the provisions of
532 the Mississippi Administrative Procedure Law and after proper
533 notice and the opportunity for a hearing, the department may
534 impose upon a private review agent, health benefit plan or health
535 insurance issuer an administrative fine not to exceed Ten Thousand
536 Dollars ($10,000.00) per violation for failure to submit a
537 requested plan of correction, failure to comply with its plan of
538 correction, or repeated violations of this act. All fines
539 collected by the department under this section shall be deposited

540 into the State General Fund. The department may also exercise all
541 authority granted to it under Section 41-83-13 to deny or revoke a
542 certificate of a private review agent for a violation of this act.
543 (2) Any person or his or her treating physician who has
544 evidence that his or her health insurance issuer or health benefit
545 plan is in violation of the provisions of this act may file a
546 complaint with the department. The department shall review all
547 complaints received and investigate all complaints that it deems
548 to state a potential violation. The department shall fairly,
549 efficiently and timely review and investigate complaints. Health
550 insurance issuers, health benefit plans and private review agents
551 found to be in violation of this act shall be penalized in
552 accordance with this section.
553 (3) The department shall have the authority to promulgate
554 rules and regulations under the Mississippi Administrative
555 Procedures Law to govern the administration of this act.
556 **SECTION 18.** **Reports to the department.** (1) By June 1,
557 2025, and each June 1 after that date, a health insurance issuer
558 shall report to the department, on a form issued by the
559 department, the following aggregated trend data, de-identified of
560 protected health information, related to the insurer's practices
561 and experience for the prior plan year for health care services
562 submitted for payment:
563 (a) The number of prior authorization requests;
564 (b) The number of prior authorization requests denied;

565 (c) The number of prior authorization appeals received;
566 (d) The number of adverse determinations reversed on
567 appeal;
568 (e) Of the total number of prior authorization
569 requests, the number of prior authorization requests that were not
570 submitted electronically;
571 (f) The ten (10) health care services that were most
572 frequently denied through prior authorization;
573 (g) The ten (10) reasons prior authorization requests
574 were most frequently denied;
575 (h) The number of claims for health care services that
576 were examined through a post-service utilization review process;
577 (i) The number and percentage of claims for health care
578 services denied through post-service utilization review; and
579 (j) The ten (10) health care services that were most
580 frequently denied as a result of post-service utilization reviews.
581 (2) All reports required by this section shall be considered
582 public records under the Mississippi Public Records Act of 1983
583 and the department shall make all reports freely available to
584 requestors and post all reports to its public website without
585 redactions.
586 **SECTION 19.** **False requests for prior authorization.** If a
587 health insurance issuer has clear and convincing evidence that a
588 health care professional or health care provider has knowingly and
589 willingly submitted false or fraudulent requests for prior

590 authorization to the health insurance issuer, the issuer shall
591 notify and provide that information to the Commissioner of
592 Insurance. After receipt of such notification and information,
593 the commissioner shall forward these reports to the Board of
594 Medical Licensure or such other licensing agency with oversight of
595 the health care provider.

596 **SECTION 20.** Section 41-83-1, Mississippi Code of 1972, is
597 amended as follows:

598 41-83-1. As used in this chapter, the following terms shall
599 be defined as follows:

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

607 (b) "Private review agent" means a
608 nonhospital-affiliated person or entity performing utilization
609 review on behalf of:

610 (i) An employer or employees in the State of
611 Mississippi; or

612 (ii) A third party that provides or administers
613 hospital and medical benefits to citizens of this state,
614 including: a health maintenance organization issued a certificate

615 of authority under and by virtue of the laws of the State of
616 Mississippi; or a health insurer, nonprofit health service plan,
617 health insurance service organization, or preferred provider
618 organization or other entity offering health insurance policies,
619 contracts or benefits in this state.

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

622 (d) "Department" means the Mississippi State Department
623 of *** * *** Insurance.

624 (e) "Certificate" means a certificate of registration
625 granted by the Mississippi State Department of *** * *** Insurance to
626 a private review agent.

627 **SECTION 21.** Section 41-83-3, Mississippi Code of 1972, is
628 amended as follows:

629 41-83-3. (1) A private review agent who approves or denies
630 payment or who recommends approval or denial of payment for
631 hospital or medical services or whose review results in approval
632 or denial of payment for hospital or medical services on a case by
633 case basis, may not conduct utilization review in this state
634 unless the Mississippi State Department of *** * *** Insurance has
635 granted the private review agent a certificate.

636 (2) The Mississippi State Department of *** * *** Insurance
637 shall issue a certificate to an applicant that has met all the
638 requirements of this chapter and all applicable regulations of the
639 department.

640 (3) A certificate issued under this chapter is not
641 transferable.
642 (4) The State Department of * * * Insurance shall adopt
643 regulations to implement the provisions of this chapter. Any
644 personal information required by the department with respect to
645 customers or patients shall be held in confidence and not
646 disclosed to the public.
647 **SECTION 22.** Section 41-83-13, Mississippi Code of 1972, is
648 amended as follows:
649 41-83-13. (1) The department shall deny a certificate to
650 any applicant if, upon review of the application, the department
651 finds that the applicant proposing to conduct utilization review
652 does not:
653 (a) Have available the services of a physician to carry
654 out its utilization review activities;
655 (b) Meet any applicable regulations the department
656 adopted under this chapter relating to the qualifications of
657 private review agents or the performance of utilization review;
658 and
659 (c) Provide assurances satisfactory to the department
660 that the procedure and policies of the private review agent will
661 protect the confidentiality of medical records and the private
662 review agent will be reasonably accessible to patients and
663 providers for five (5) working days a week during normal business
664 hours in this state.

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

669 (3) Before denying or revoking a certificate under this
670 section, the department shall provide the applicant or certificate
671 holder with reasonable time to supply additional information
672 demonstrating compliance with the requirements of this chapter and
673 the opportunity to request a hearing. If an applicant or
674 certificate holder requests a hearing, the department shall send a
675 hearing notice and conduct a hearing *** * ***.

676 **SECTION 23.** Section 41-83-31, Mississippi Code of 1972, is
677 amended as follows:

678 41-83-31. Any program of utilization review with regard to
679 hospital, medical or other health care services provided in this
680 state<u>, including, but not limited to, any prior authorization as</u>
681 <u>defined in Section 4 of this act,</u> shall comply with the following:

682 (a) No determination adverse to a patient or to any
683 affected health care provider shall be made on any question
684 relating to the necessity or justification for any form of
685 hospital, medical or other health care services without prior
686 evaluation and concurrence in the adverse determination by a
687 physician licensed to practice in *** * *** <u>any United States</u>
688 <u>jurisdiction and certified by the board(s) of the American Board</u>
689 <u>of Medical Specialists or the American Board of Osteopathy within</u>

690 the relevant specialty. The physician who made the adverse
691 determination shall discuss the reasons for any adverse
692 determination with the affected health care provider, if the
693 provider so requests. The physician shall comply with this
694 request within *** * *** seven (7) calendar days of being notified of
695 a request. Adverse determination by a physician shall not be
696 grounds for any disciplinary action against the physician by the
697 State Board of Medical Licensure. The provisions of this
698 paragraph (a) do not apply to initial adverse determinations made
699 under the provisions of the Mississippi Prior Authorization Reform
700 Act, but do apply to reviews of adverse determinations on appeal.
701 (b) Any determination regarding hospital, medical or
702 other health care services rendered or to be rendered to a patient
703 which may result in a denial of third-party reimbursement or a
704 denial of precertification for that service shall include the
705 evaluation, findings and concurrence of a physician trained in the
706 relevant specialty or subspecialty and certified by the board(s)
707 of the American Board of Medical Specialists or the American Board
708 of Osteopathy within the relevant specialty, if requested by the
709 patient's physician, to make a final determination that care
710 rendered or to be rendered was, is, or may be medically
711 inappropriate.
712 *** * ***
713 **SECTION 24.** Section 83-1-101, Mississippi Code of 1972, is
714 amended as follows:

715 83-1-101. Notwithstanding any other provision of law to the
716 contrary, and except as provided herein, any person or other
717 entity which provides coverage in this state for medical,
718 surgical, chiropractic, physical therapy, speech pathology,
719 audiology, professional mental health, dental, hospital, or
720 optometric expenses, whether such coverage is by direct payment,
721 reimbursement *** * *** or otherwise, and all private review agents
722 covered by Sections 41-83-1 through 41-83-31, shall be presumed to
723 be subject to the jurisdiction of the State Insurance Department,
724 unless (a) the person or other entity shows that while providing
725 such services it is subject to the jurisdiction of another agency
726 of this state, any subdivisions thereof, or the federal
727 government; or (b) the person or other entity is providing
728 coverage under the Direct Primary Care Act in Sections 83-81-1
729 through 83-81-11.

730 **SECTION 25.** Section 41-83-21, Mississippi Code of 1972, is
731 amended as follows:

732 41-83-21. Notwithstanding language to the contrary elsewhere
733 contained herein, if a licensed physician certifies in writing to
734 an insurer within seventy-two (72) hours of an admission that the
735 insured person admitted was in need of immediate hospital care for
736 emergency services, such shall constitute a prima facie case of
737 the medical necessity of the admission. To overcome this, the
738 entity requesting the utilization review and/or the private review

739 agent must show by clear and convincing evidence that the admitted
740 person was not in need of immediate hospital care.

741 **SECTION 26.** Section 83-9-6.3, Mississippi Code of 1972, is
742 amended as follows:

743 83-9-6.3. (1) As used in this section:

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

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

763 coordinated care organization program or health maintenance
764 organization program implemented by the division.
765 (c) "Prior authorization" means a utilization
766 management criterion used to seek permission or waiver of a drug
767 to be covered under a health benefit plan that provides
768 prescription drug benefits.
769 (d) "Prior authorization form" means a standardized,
770 uniform application developed by a health insurance issuer for the
771 purpose of obtaining prior authorization.
772 (2) Notwithstanding any other provision of law to the
773 contrary, in order to establish uniformity in the submission of
774 prior authorization forms, on or after January 1, 2014, a health
775 insurance issuer shall use only a single, standardized prior
776 authorization form for obtaining any prior authorization for
777 prescription drug benefits. The form shall not exceed two (2)
778 pages in length, excluding any instructions or guiding
779 documentation. The form shall also be made available
780 electronically, and the prescribing provider may submit the
781 completed form electronically to the health benefit plan.
782 Additionally, the health insurance issuer shall submit its prior
783 authorization forms to the Mississippi Department of Insurance to
784 be kept on file on or after January 1, 2014. A copy of any
785 subsequent replacements or modifications of a health insurance
786 issuer's prior authorization form shall be filed with the

787 Mississippi Department of Insurance within fifteen (15) days prior
788 to use or implementation of such replacements or modifications.
789 (3) A health insurance issuer shall respond within two (2)
790 business days upon receipt of a completed prior authorization
791 request from a prescribing provider that was submitted using the
792 standardized prior authorization form required by subsection (2)
793 of this section. Notwithstanding the foregoing provisions of this
794 subsection, health insurance issuers shall comply with Section 8
795 of this act in regard to prior authorizations in urgent
796 circumstances.
797 **SECTION 27.** Section 41-83-5, Mississippi Code of 1972, is
798 brought forward as follows:
799 41-83-5. No certificate is required for those private review
800 agents conducting general in-house utilization review for
801 hospitals, home health agencies, preferred provider organizations
802 or other managed care entities, clinics, private physician offices
803 or any other health facility or entity, so long as the review does
804 not result in the approval or denial of payment for hospital or
805 medical services for a particular case. Such general in-house
806 utilization review is completely exempt from the provisions of
807 this chapter.
808 **SECTION 28.** Section 41-83-7, Mississippi Code of 1972, is
809 brought forward as follows:
810 41-83-7. (1) An applicant for a certificate shall:
811 (a) Submit an application to the department; and

812 (b) Pay to the department the application fee
813 established by the department through regulation.
814 (2) The application shall:
815 (a) Be on a form and accompanied by any supporting
816 documentation that the department requires; and
817 (b) Be signed and verified by the applicant.
818 (3) The application fee required under this section shall be
819 sufficient to pay for the administrative cost of the certification
820 program and any other cost associated with carrying out the
821 provisions of this chapter.
822 **SECTION 29.** Section 41-83-9, Mississippi Code of 1972, is
823 brought forward as follows:
824 41-83-9. In conjunction with the application, the private
825 review agent shall submit information that the department requires
826 including:
827 (a) A utilization review plan that includes a
828 description of review criteria, standards and procedures to be
829 used in evaluating proposed or delivered hospital and medical care
830 and the provisions by which patients, physicians or hospitals may
831 seek reconsideration or appeal of adverse decisions by the private
832 review agent;
833 (b) The type and qualifications of the personnel either
834 employed or under contract to perform the utilization review;

835 (c) The procedures and policies to insure that a
836 representative of the private review agent is reasonably
837 accessible to patients and providers at all times in this state;
838 (d) The policies and procedures to insure that all
839 applicable state and federal laws to protect the confidentiality
840 of individual medical records are followed;
841 (e) A copy of the materials designed to inform
842 applicable patients and providers of the requirements of the
843 utilization review plan; and
844 (f) A list of the third party payors for which the
845 private review agent is performing utilization review in this
846 state.
847 **SECTION 30.** Section 41-83-11, Mississippi Code of 1972, is
848 brought forward as follows:
849 41-83-11. (1) A certificate expires on the second
850 anniversary of its effective date unless the certificate is
851 renewed for a two-year term as provided in this section.
852 (2) Before the certificate expires, a certificate may be
853 renewed for an additional two-year term if the applicant:
854 (a) Otherwise is entitled to the certificate;
855 (b) Pays the department the renewal fee set by the
856 department through regulation; and
857 (c) Submits to the department a renewal application on
858 the form that the department requires and satisfactory evidence of

859 compliance with any requirement of this chapter for certificate
860 renewal.

861 **SECTION 31.** Section 41-83-15, Mississippi Code of 1972, is
862 brought forward as follows:

863 41-83-15. The department shall establish reporting
864 requirements to:

865 (a) Evaluate the effectiveness of private review
866 agents; and

867 (b) Determine if the utilization review programs are in
868 compliance with the provisions of this section and applicable
869 regulations.

870 **SECTION 32.** Section 41-83-17, Mississippi Code of 1972, is
871 brought forward as follows:

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

881 **SECTION 33.** Section 41-83-19, Mississippi Code of 1972, is
882 brought forward as follows:

883 41-83-19. A person who violates any provision of this
884 chapter or any regulation adopted under this chapter is guilty of
885 a misdemeanor and on conviction is subject to a penalty not
886 exceeding One Thousand Dollars ($1,000.00).

887 **SECTION 34.** Section 41-83-23, Mississippi Code of 1972, is
888 brought forward as follows:

889 41-83-23. Any person aggrieved by a final decision of the
890 department or a private review agent in a contested case under
891 this chapter shall have the right of judicial appeal to the
892 chancery court of the county of the residence of the aggrieved
893 person.

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

897 **SECTION 35.** Section 41-83-25, Mississippi Code of 1972, is
898 brought forward as follows:

899 41-83-25. (1) Every health insurance plan proposing to
900 issue or deliver a health insurance policy or contract or
901 administer a health benefit program which provides for the
902 coverage of hospital and medical benefits and the utilization
903 review of those benefits shall:

904 (a) Have a certificate in accordance with this chapter;
905 or

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

908 (2) Notwithstanding any other provisions of this chapter,
909 for claims where the medical necessity of the provision of a
910 covered benefit is disputed, a health service plan that does not
911 meet the requirements of subsection (1) of this section shall pay
912 any person or hospital entitled to reimbursement under the policy
913 or contract.

914 **SECTION 36.** Section 41-83-27, Mississippi Code of 1972, is
915 brought forward as follows:

916 41-83-27. (1) Every insurer proposing to issue or deliver a
917 health insurance policy or contract or administer a health benefit
918 program which provides for the coverage of hospital and medical
919 benefits and the utilization review of such benefits shall:

920 (a) Have a certificate in accordance with this chapter;
921 or

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

924 (2) Notwithstanding any provision of this chapter, for
925 claims where the medical necessity of the provision of a covered
926 benefit is disputed, an insurer that does not meet the
927 requirements of subsection (1) of this section shall pay any
928 person or hospital entitled to reimbursement under the policy or
929 contract.

930 **SECTION 37.** Section 41-83-29, Mississippi Code of 1972, is
931 brought forward as follows:

932 41-83-29. Any health insurer proposing to issue or deliver
933 in this state a group or blanket health insurance policy or
934 administer a health benefit program which provides for the
935 coverage of hospital and medical benefits and the utilization
936 review of such benefits shall:
937 (a) Have a certificate in accordance with this chapter;
938 or
939 (b) Contract with a private review agent that has a
940 certificate in accordance with this chapter.
941 **SECTION 38.** This act shall take effect and be in force from
942 and after July 1, 2024.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

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 REQUIRE HEALTH
21 INSURANCE ISSUERS TO GIVE CERTAIN NOTIFICATIONS WHEN MAKING AN
22 ADVERSE DETERMINATION; TO ESTABLISH THE QUALIFICATIONS FOR

23 PERSONNEL WHO REVIEW APPEALS OF PRIOR AUTHORIZATIONS; TO REQUIRE
24 HEALTH INSURANCE ISSUERS TO PERIODICALLY REVIEW ITS PRIOR
25 AUTHORIZATION REQUIREMENTS AND TO CONSIDER REMOVAL OF THESE
26 REQUIREMENTS IN CERTAIN CASES; TO PROVIDE THAT A HEALTH INSURANCE
27 ISSUER MAY NOT REVOKE OR FURTHER LIMIT, CONDITION OR RESTRICT A
28 PREVIOUSLY ISSUED PRIOR AUTHORIZATION WHILE IT REMAINS VALID UNDER
29 THIS ACT UNLESS CERTAIN EXCLUSIONS ARE APPLICABLE; TO PROVIDE HOW
30 LONG PRIOR AUTHORIZATION APPROVALS SHALL BE VALID; TO PROVIDE HOW
31 LONG THE PRIOR AUTHORIZATIONS FOR CHRONIC CONDITIONS SHALL BE
32 VALID; TO ESTABLISH THE PROCEDURE FOR THE CONTINUITY OF PRIOR
33 APPROVALS FROM PREVIOUS HEALTH INSURANCE ISSUERS TO CURRENT
34 ISSUERS; TO PROVIDE THAT A FAILURE BY A HEALTH INSURANCE ISSUER TO
35 COMPLY WITH THE DEADLINES AND OTHER REQUIREMENTS SPECIFIED IN THIS
36 ACT SHALL RESULT IN ANY HEALTH CARE SERVICES SUBJECT TO REVIEW TO
37 BE AUTOMATICALLY DEEMED AUTHORIZED BY THE HEALTH INSURANCE ISSUER
38 OR ITS CONTRACTED PRIVATE REVIEW AGENT; TO AUTHORIZE THE
39 DEPARTMENT OF INSURANCE TO ISSUE CEASE AND DESIST ORDERS TO HEALTH
40 INSURANCE ISSUERS OR PRIVATE REVIEW AGENTS; TO AUTHORIZE THE STATE
41 DEPARTMENT OF INSURANCE TO IMPOSE UPON A PRIVATE REVIEW AGENT,
42 HEALTH BENEFIT PLAN OR HEALTH INSURANCE ISSUER AN ADMINISTRATIVE
43 FINE NOT TO EXCEED $10,000 PER VIOLATION OF THE ACT; TO REQUIRE
44 HEALTH INSURANCE ISSUERS TO REPORT TO THE DEPARTMENT CERTAIN DATA;
45 TO REQUIRE HEALTH INSURANCE ISSUERS TO NOTIFY THE COMMISSIONER OF
46 INSURANCE OF SUSPECTED SUBMISSIONS OF FALSE REQUESTS FOR PRIOR
47 AUTHORIZATION; TO REQUIRE THE COMMISSIONER TO HAVE AN
48 ADMINISTRATIVE HEARING ON SUCH MATTERS TO RESOLVE THE ISSUE; TO
49 AMEND SECTION 41-83-31, MISSISSIPPI CODE OF 1972, TO CONFORM AND
50 TO SET CERTAIN QUALIFICATIONS AND TIME CONSTRAINTS FOR PHYSICIANS
51 MAKING ADVERSE DETERMINATIONS THROUGH ANY PROGRAM OF UTILIZATION
52 REVIEW; TO AMEND SECTIONS 41-83-1, 41-83-3, 41-83-13, 41-83-21,
53 83-1-101 AND 83-9-6.3, MISSISSIPPI CODE OF 1972, TO CONFORM WITH
54 THE PROVISIONS OF THIS ACT; TO BRING FORWARD SECTIONS 41-83-5,
55 41-83-7, 41-83-9, 41-83-11, 41-83-15, 41-83-17, 41-83-19,
56 41-83-23, 41-83-25, 41-83-27 AND 41-83-29, MISSISSIPPI CODE OF
57 1972, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED
58 PURPOSES.