

By: Representative Powell

To: Insurance

HOUSE BILL NO. 339

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

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

9 **SECTION 1.** (1) All individual and group health insurance  
 10 policies providing coverage on an expense incurred basis,  
 11 individual and group service or indemnity type contracts issued by  
 12 a nonprofit corporation, individual and group service contracts  
 13 issued by a health maintenance organization, all self-insured  
 14 group arrangements to the extent not preempted by federal law and  
 15 all managed health care delivery entities of any type or  
 16 description that are delivered, issued for delivery, continued or  
 17 renewed on or after July 1, 2024, and providing coverage to any  
 18 resident of this state may not modify, on renewal of the policy,  
 19 plan or contract, an insured's contracted benefit level for any  
 20 prescription drug that was approved or covered under the plan in



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

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

31 (a) Removing a drug from a formulary;

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

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

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

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

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

39 and

40 (g) Reducing the maximum drug coverage amount.

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



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

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

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

54                   **SECTION 2.** This act shall take effect and be in force from  
55 and after July 1, 2024.

