MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representative Zuber

To: Public Health and Human Services

HOUSE BILL NO. 420

1 AN ACT TO CREATE THE MISSISSIPPI PRIOR AUTHORIZATION REFORM
2 ACT; TO PROVIDE THE SCOPE OF THE ACT AND DEFINITIONS; TO REQUIRE
3 THE DEPARTMENT OF INSURANCE TO PROMULGATE RULES AND REGULATIONS
4 THAT PROVIDE FOR THE DISCLOSURE AND REVIEW REQUIREMENTS FOR PRIOR
5 AUTHORIZATION; TO PROVIDE THAT IF ANY HEALTH INSURANCE ISSUER
6 REQUIRES PRIOR AUTHORIZATION OF A HEALTH CARE SERVICE, THE
7 INSURER, OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION, SHALL,
8 BY JANUARY 1, 2026, MAKE AVAILABLE A STANDARDIZED ELECTRONIC PRIOR
9 AUTHORIZATION REQUEST TRANSACTION PROCESS; TO REQUIRE ALL HEALTH
10 CARE PROFESSIONALS AND PROVIDERS TO USE THE STANDARDIZED
11 ELECTRONIC PRIOR AUTHORIZATION REQUEST TRANSACTION PROCESS BY
12 JANUARY 1, 2028; TO PROVIDE THE TIME FOR EITHER APPROVING OR
13 PROVIDING AN ADVERSE DETERMINATION TO A PRIOR AUTHORIZATION
14 REQUEST IN BOTH NONURGENT AND URGENT SITUATIONS; TO PROVIDE THE
15 PERSONNEL QUALIFIED TO MAKE ADVERSE DETERMINATIONS; TO REQUIRE THE
16 DEPARTMENT OF INSURANCE TO PROMULGATE RULES AND REGULATIONS THAT
17 PROVIDE THE NOTIFICATION REQUIREMENTS TO AN ENROLLEE AND AN
18 ENROLLEE'S HEALTH CARE PROFESSIONAL AND PROVIDER IF A HEALTH
19 INSURANCE ISSUER MAKES AN ADVERSE DETERMINATION; TO PROVIDE THE
20 PERSONNEL WHO ARE QUALIFIED TO REVIEW APPEALS OF ADVERSE
21 DETERMINATIONS; TO REQUIRE A HEALTH INSURANCE ISSUER TO
22 PERIODICALLY REVIEW ITS PRIOR AUTHORIZATION REQUIREMENTS; TO
23 REQUIRE THE DEPARTMENT OF INSURANCE PROMULGATE RULES AND
24 REGULATIONS THAT PROVIDE FOR THE REVOCATION OF PRIOR
25 AUTHORIZATIONS; TO PROVIDE HOW LONG THE LENGTH OF APPROVALS MAY BE
26 FOR PRIOR AUTHORIZATIONS; TO REQUIRE THE DEPARTMENT OF INSURANCE
27 TO PROMULGATE RULES AND REGULATIONS FOR HOW LONG THE APPROVAL OF A
28 PRIOR AUTHORIZATION MAY LAST FOR A CHRONIC CONDITION; TO REQUIRE
29 THE DEPARTMENT OF INSURANCE TO PROMULGATE RULES AND REGULATIONS
30 THAT PROVIDE HOW LONG A HEALTH INSURANCE ISSUER MUST HONOR THE
31 PRIOR AUTHORIZATION GRANTED TO AN ENROLLEE FROM A PREVIOUS HEALTH
32 INSURANCE ISSUER; TO PROVIDE THAT THE FAILURE BY A HEALTH
33 INSURANCE ISSUER TO COMPLY WITH DEADLINES AND OTHER REQUIREMENTS
34 SHALL RESULT IN ANY HEALTH CARE SERVICES SUBJECT TO REVIEW BEING

35 AUTOMATICALLY DEEMED AUTHORIZED BY THE HEALTH INSURANCE ISSUER; TO
36 PROVIDE FOR THE ENFORCEMENT AND ADMINISTRATION OF THIS ACT; TO
37 PROVIDE THE REPORTS THAT MUST BE FILED WITH THE DEPARTMENT OF
38 INSURANCE EACH YEAR; TO AUTHORIZE THE DEPARTMENT OF INSURANCE TO
39 PROMULGATE ANY OTHER RULES AND REGULATIONS AS NECESSARY TO
40 EFFECTUATE THE MISSISSIPPI PRIOR AUTHORIZATION ACT; TO BRING
41 FORWARD SECTIONS 41-83-31 AND 83-9-6.3, MISSISSIPPI CODE OF 1972,
42 FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

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

46 **SECTION 2.** **Applicability and scope.** This act shall apply to
47 every health insurance issuer and all health benefit plans, as
48 both terms are defined in Section 83-9-6.3, and all private review
49 agents and utilization review plans, as both terms are defined in
50 Section 41-83-1, including employee or employer self-insured
51 health benefit plans under the federal Employee Retirement Income
52 Security Act of 1974, health care provided pursuant to the
53 Workers' Compensation Act and the Mississippi State and School
54 Employees' Life and Health Insurance Plan. This act shall not
55 diminish the duties and responsibilities under other federal or
56 state law or rules promulgated thereunder that are applicable to a
57 health insurer, health insurance issuer, health benefit plan,
58 private review agent, or utilization review plan, including, but
59 not limited to, the requirement of a certificate in accordance
60 with Section 41-83-3.

61 **SECTION 3.** **Definitions.** For the purposes of this act, the
62 following words and phrases shall have the meanings as defined in
63 this section unless the context clearly indicates otherwise:

64 (a) "Adverse determination" means a determination by a
65 health insurance issuer that, based upon the information provided,
66 a request for a benefit under the health insurance issuer's health
67 benefit plan upon application of any utilization review technique
68 does not meet the health insurance issuer's requirements for
69 medical necessity, appropriateness, health care setting, level of
70 care, or effectiveness or is determined to be experimental or
71 investigational and the requested benefit is therefore denied,
72 reduced, or terminated or payment is not provided or made, in
73 whole or in part, for the benefit; the denial, reduction, or
74 termination of or failure to provide or make payment, in whole or
75 in part; or a rescission of coverage determination, which does not
76 include a cancellation or discontinuance of coverage that is
77 attributable to a failure to timely pay required premiums or
78 contributions towards the cost of coverage.
79 (b) "Appeal" means a formal request, in writing, to
80 reconsider an adverse determination.
81 (c) "Approval" means a determination by a health
82 insurance issuer that a health care service has been reviewed and,
83 based on the information provided, satisfies the health insurance
84 issuers requirements for medical necessity and appropriateness.
85 (d) "Clinical review criteria" means the written
86 screening procedures, decision abstracts, clinical protocols, and
87 practice guidelines used by a health insurance issuer to determine
88 the necessity and appropriateness of health care services.

89 (e) "Department" means the Mississippi Department of
90 Insurance.
91 (f) "Emergency medical condition" means a medical
92 condition manifesting itself by acute symptoms of sufficient
93 severity, including, but not limited to, severe pain, such that a
94 prudent layperson who possesses an average knowledge of health and
95 medicine could reasonably expect the absence of immediate medical
96 attention to result in: (i) placing the health of the individual
97 or, with respect to a pregnant woman, the health of the woman or
98 her unborn child, in serious jeopardy; (ii) serious impairment to
99 bodily functions; or (iii) serious dysfunction of any bodily organ
100 or part.
101 (g) "Emergency services" means health care items and
102 services furnished or required to evaluate and treat an emergency
103 medical condition.
104 (h) "Enrollee" means any person and his or her
105 dependents enrolled in or covered by a health care plan.
106 (i) "Health care professional" means a physician, a
107 registered professional nurse, or other individual appropriately
108 licensed or registered to provide health care services.
109 (j) "Health care provider" means any physician,
110 hospital, ambulatory surgery center, or other person or facility
111 that is licensed or otherwise authorized to deliver health care
112 services.

113 (k) "Health care service" means any services or level
114 of services included in the furnishing to an individual of medical
115 care or the hospitalization incident to the furnishing of such
116 care, as well as the furnishing to any person of any other
117 services for the purpose of preventing, alleviating, curing, or
118 healing human illness or injury, including behavioral health,
119 mental health, home health, and pharmaceutical services and
120 products.
121 (l) "Health insurance issuer" has the meaning given to
122 that term in Section 83-9-6.3. Any provision of this act that
123 applies to a "health insurance issuer" also applies to any person
124 or entity covered under the scope of this act in Section 3.
125 (m) "Medically necessary" means a health care
126 professional exercising prudent clinical judgment would provide
127 care to a patient for the purpose of preventing, diagnosing, or
128 treating an illness, injury, disease, or its symptoms and that
129 are: (i) in accordance with professional, evidence-based medicine
130 and generally accepted standards of good medical practice and
131 care; (ii) clinically appropriate in terms of type, frequency,
132 extent, site, and duration and are considered effective for the
133 patient's illness, injury, or disease; and not primarily for the
134 convenience of the patient, treating physician; other health care
135 professional, caregiver, family member, or other interested party,
136 but focused on what is best for the patient's health outcome.

137 (n) "Physician" means any person with a valid doctor of
138 medicine, doctor of osteopathy or doctor of podiatry degree who is
139 currently and appropriately licensed to practice medicine within
140 the scope of such license.
141 (o) "Prior authorization" means the process by which a
142 health insurance issuer determines the medical necessity and
143 medical appropriateness of an otherwise covered health care
144 service before the rendering of such health care service. "Prior
145 authorization" includes any health insurance issuer's requirement
146 that an enrollee, health care professional, or health care
147 provider notify the health insurance issuer before or at the time
148 of providing a health care service.
149 (p) "Urgent health care service" means a health care
150 service with respect to which the application of the time periods
151 for making a nonexpedited prior authorization that in the opinion
152 of a treating health care professional or health care provider
153 with knowledge of the enrollee's medical condition: (i) could
154 seriously jeopardize the life or health of the enrollee or the
155 ability of the enrollee to regain maximum function; or (ii) could
156 subject the enrollee to severe pain that cannot be adequately
157 managed without the care or treatment that is the subject of the
158 utilization review.
159 (q) "Urgent health care service" does not include
160 emergency services.

161 (r) "Private review agent" has the meaning given to
162 that term in Section 41-83-1.
163 **SECTION 4. Disclosure and review of prior authorization**
164 **requirements.** The department shall promulgate rules and
165 regulations that provide for the disclosure and review
166 requirements for prior authorizations. Such rules and regulations
167 shall require a health insurance issuer to comply with at least
168 the following requirements:
169 (a) Maintain a complete list of services for which
170 prior authorization is required, including for all services where
171 prior authorization is performed by an entity under contract with
172 the health insurance issuer.
173 (b) Make any current prior authorization requirements
174 and restrictions for health care services other than
175 pharmaceutical services and products, including the written
176 clinical review criteria, readily accessible, described in detail,
177 written in easily understandable language and conspicuously posted
178 on its website to enrollees, health care professionals, and health
179 care providers. Content published by a third party and licensed
180 for use by a health insurance issuer may be made available through
181 the health insurance issuers secure, password protected website so
182 long as the access requirements of the website do not unreasonably
183 restrict access.

184 (c) Provide the following information on the website
185 for each health care service other than pharmaceutical services
186 and products that is subject to prior authorization:
187 (i) When prior authorization became required for
188 policies issued or health benefit plan documents delivered in
189 Mississippi, including the effective date or dates and the
190 termination date or dates, if applicable, in Mississippi;
191 (ii) The date the Mississippi-specific requirement
192 was listed on the health insurance issuer's, health benefit
193 plan's, or private review agent's website;
194 (iii) Where applicable, the date that prior
195 authorization was removed for Mississippi; and
196 (iv) Where applicable, access to a standardized
197 electronic prior authorization request transaction process.
198 (d) Establish the clinical review criteria based on the
199 following factors:
200 (i) Generally accepted standards except where
201 state law provides its own standard;
202 (ii) Quality of care and access to needed health
203 care services;
204 (iii) Evidence-based;
205 (iv) Sufficiently flexible to allow deviations
206 from norms when justified on a case-by-case basis; and

207 (v) Evaluated and updated as provided in the rules
208 and regulations established by the department, but such time frame
209 shall not be less than annually.
210 (e) Not deny a claim for failure to obtain prior
211 authorization if the prior authorization requirement was not in
212 effect on the date of service on the claim.
213 (f) When either implementing a new prior authorization
214 requirement for health care services other than pharmaceutical
215 services and products, or restricting or amending an existing
216 requirement or restriction for health care services other than
217 pharmaceutical services and products, provide the contracted
218 health care professionals and contracted health care providers of
219 enrollees notice of the new or amended requirement or amendment no
220 less than sixty (60) days before the requirement or restriction is
221 implemented. Such notice requirement may be met if the health
222 insurance issuer posts the notice on its website. The health
223 insurance issuer shall ensure that the new or amended requirement
224 is not implemented unless the health insurance issuer's website
225 has been updated to reflect the new or amended requirement or
226 restriction.
227 (g) Make statistics available regarding prior
228 authorization approvals and denials on their website in a readily
229 accessible format. The statistics must be updated annually and
230 include all of the following information:

231 (i) A list of all health care services other than
232 pharmaceutical services and products that are subject to prior
233 authorization;
234 (ii) The total number of prior authorization
235 requests received;
236 (iii) The number of prior authorization requests
237 denied during the previous plan year by the health insurance
238 issuer, health benefit plan, or private review agent with respect
239 to each service described in paragraph (i) and the top five (5)
240 reasons for denial;
241 (iv) The number of requests described in paragraph
242 (iii) that were appealed, the number of the appealed requests that
243 upheld the adverse determination, and the number of appealed
244 requests that reversed the adverse determination;
245 (v) The average time between submission and
246 response; and
247 (vi) Any other information, including any
248 information related to pharmaceutical services and products, as
249 the department determines appropriate.
250 **SECTION 5.** **Standardized electronic prior authorizations.**
251 (1) If any health insurance issuer requires prior
252 authorization of a health care service, the insurer, or its
253 designee utilization review organization, shall, by January 1,
254 2026, make available a standardized electronic prior authorization
255 request transaction process using an Internet webpage, Internet

256 webpage portal, or similar electronic, Internet, and web-based
257 system.

258 (2) After January 1, 2026, any health insurance issuer that
259 receives a prior authorization request from a health care
260 professional or health care provider who does not submit the prior
261 authorization request with the standardized electronic prior
262 authorization request transaction process created in paragraph (a)
263 of this section shall not be subject to the timelines put in place
264 by the department as provided in this act and shall not be subject
265 to the fines provided in this act.

266 (3) By January 1, 2028, all health care professionals and
267 health care providers shall be required to use the standardized
268 electronic prior authorization request transaction process created
269 in paragraph (a) of this section.

270 (4) (a) The department shall promulgate rules and
271 regulations as necessary to effectuate the provisions of this
272 section.

273 (b) The department shall also promulgate rules and
274 regulations regarding any written notice or other form or document
275 that the department determines shall be in writing.

276 **SECTION 6. Prior authorizations in nonurgent circumstances.**
277 Notwithstanding any other provision of law, if a health insurance
278 issuer requires prior authorization of a health care service, the
279 health insurance issuer must make an approval or adverse
280 determination and notify the enrollee, the enrollee's health care

281 professional, and the enrollee's health care provider of the
282 approval or adverse determination as provided in rules and
283 regulations promulgated by the department, but no later than five
284 (5) calendar days after obtaining all necessary information to
285 make the approval or adverse determination.

286 As used in this section, "necessary information" includes the
287 results of any face-to-face clinical evaluation, second opinion,
288 or other clinical information that is directly applicable to the
289 requested service that may be required.

290 **SECTION 7.** **Prior authorizations in urgent circumstances.**

291 (1) If requested by a treating health care provider or
292 health care professional for an enrollee, and notwithstanding any
293 other provision of law, a health insurance issuer must render an
294 approval or adverse determination concerning urgent care services
295 and notify the enrollee, the enrollee's health care professional,
296 and the enrollee's health care provider of that approval or
297 adverse determination as provided in rules and regulations
298 promulgated by the department, but not later than forty-eight (48)
299 hours after receiving all information needed to complete the
300 review of the requested health care services, which shall include
301 an explanation on what makes the prior authorization request
302 urgent.

303 (2) To facilitate a prior authorization determination as
304 provided in this section, a health insurance issuer must establish
305 a mechanism to ensure health care professionals have access to

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

310 **SECTION 8. Personnel qualified to make adverse**
311 **determinations.** (1) A health insurance issuer must ensure that
312 all adverse determinations are made by a physician when the
313 request is by a physician or a representative of a physician. The
314 physician must:

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

317 (b) Any other qualifications deemed necessary by rules
318 and regulations promulgated by the department.

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

323 **SECTION 9. Notifications for adverse determinations.** The
324 department shall promulgate rules and regulations that provide the
325 notification requirements to an enrollee, the enrollee's health
326 care professional, and the enrollee's health care provider if a
327 health insurance issuer makes an adverse determination. Such
328 notification requirements shall include at least the following:

329 (a) The reasons for the adverse determination and
330 related evidence-based criteria, including a description of any
331 missing or insufficient documentation;
332 (b) The right to appeal the adverse determination;
333 (c) Instructions on how to file the appeal; and
334 (d) Additional documentation necessary to support the
335 appeal as provided by the department.
336 **SECTION 10.** **Personnel qualified to review appeals of adverse**
337 **determinations.** (1) A health insurance issuer shall ensure that
338 all appeals of an adverse determination for a health care service
339 other than pharmaceutical services or products are reviewed by a
340 physician, and all appeals of an adverse determination for a
341 pharmaceutical service or product are reviewed by a pharmacist,
342 when the request is by a physician or a representative of a
343 physician. The department shall issue rules and regulations on
344 the qualifications of the physician or pharmacist. Such rules and
345 regulations shall at least require the physician or pharmacist to
346 have the following qualifications:
347 (a) Possess a current and valid nonrestricted license
348 to practice medicine by the Mississippi State Board of Medical
349 Licensure;
350 (b) Be certified by the Board(s) of the American Board
351 of Medical Specialists or the American Board of Osteopathy within
352 the relevant specialty of a physician who typically manages the
353 medical condition or disease;

354 (c) Be knowledgeable of, and have experience providing,
355 the health care services under appeal;
356 (d) Not have been directly involved in making the
357 adverse determination; and
358 (e) Consider all known clinical aspects of the health
359 care service under review, including, but not limited to, a review
360 of all pertinent medical records provided to the health insurance
361 issuer by the enrollee's health care professional or health care
362 provider and any medical literature provided to the health
363 insurance issuer by the health care professional or health care
364 provider.
365 (2) Notwithstanding the foregoing, a licensed health care
366 professional who satisfies the requirements in this section may
367 review appeal requests submitted by a health care professional
368 licensed in the same profession.
369 **SECTION 11. Insurer review of prior authorization**
370 **requirements.** A health insurance issuer shall periodically review
371 its prior authorization requirements and consider removal of prior
372 authorization requirements as provided by the department in its
373 rules and regulations.
374 **SECTION 12. Revocation of prior authorizations.** (1) The
375 department shall promulgate rules and regulations providing for
376 the revocation of prior authorizations. Such rules and
377 regulations shall include at least the following:

378 (a) A health insurance issuer may not revoke or further
379 limit, condition, or restrict a previously issued prior
380 authorization approval while it remains valid under this act.
381 (b) Notwithstanding any other provision of law, if a
382 claim is properly coded and submitted timely to a health insurance
383 issuer, the health insurance issuer shall make payment according
384 to the terms of coverage on claims for health care services for
385 which prior authorization was required and approval received
386 before the rendering of health care services, unless one of the
387 following occurs:
388 (i) It is timely determined that the enrollee's
389 health care professional or health care provider knowingly
390 provided health care services that required prior authorization
391 from the health insurance issuer or its contracted private review
392 agent without first obtaining prior authorization for those health
393 care services;
394 (ii) It is timely determined that the health care
395 services claimed were not performed;
396 (iii) It is timely determined that the enrollee
397 receiving such health care services was not an enrollee of the
398 health care plan; or
399 (iv) The approval was based upon a material
400 misrepresentation by the enrollee, health care professional, or
401 health care provider; as used in this subparagraph, "material"
402 means a fact or situation that is not merely technical in nature

403 and results or could result in a substantial change in the
404 situation.
405 (2) Nothing in this section shall preclude a private review
406 agent or a health insurance issuer from performing post-service
407 reviews of health care claims for purposes of payment integrity or
408 for the prevention of fraud, waste, or abuse.
409 **SECTION 13.** **Length of approvals.** The department shall
410 promulgate rules and regulations that provide how long a prior
411 authorization approval shall be valid. Any chemotherapy treatment
412 for any type of cancer, when subject to a prior authorization,
413 shall be valid for the entirety of the treatment plan as
414 determined by the treating health care provider or health care
415 professional, regardless of the payer. The department shall
416 provide that the approval period shall be effective regardless of
417 any changes, including any changes in dosage for a prescription
418 drug prescribed by the health care professional; however, all
419 dosage increases must be based on established evidentiary
420 standards. Nothing in this section shall prohibit a health
421 insurance issuer from having safety edits in place. The
422 provisions of this section shall not apply to the prescription of
423 benzodiazepines or Schedule II narcotic drugs, such as opioids.
424 Nothing in this section shall require a policy or plan to cover
425 any pharmaceutical service or product that is not FDA approved or
426 any care, treatment, or services for any health condition that the
427 terms of coverage otherwise completely exclude from the policy's

428 or plan's covered benefits without regard for whether the care,
429 treatment, or services are medically necessary.

430 **SECTION 14.** **Approvals for chronic conditions.** If a health
431 insurance issuer requires a prior authorization for a recurring
432 health care service or maintenance medication for the treatment of
433 a chronic or long-term condition, the department shall promulgate
434 rules and regulations that provide how long that prior approval
435 shall remain valid. This section shall not apply to the
436 prescription of benzodiazepines or Schedule II narcotic drugs,
437 such as opioids. Nothing in this section shall require a policy
438 to cover any pharmaceutical service or product that is not FDA
439 approved or any care, treatment, or services for any health
440 condition that the terms of coverage otherwise completely exclude
441 from the policy's covered benefits without regard for whether the
442 care, treatment, or services are medically necessary.

443 **SECTION 15.** **Continuity of prior approvals.** (1) When a new
444 health insurance issuer receives information documenting a prior
445 authorization approval from the enrollee or from the enrollee's
446 health care professional or health care provider, the department
447 shall promulgate rules and regulations that provide how long a
448 health insurance issuer must honor the prior authorization granted
449 to an enrollee from a previous health insurance issuer; however,
450 such period of time shall not be less than ninety (90) days.

451 (2) The department shall promulgate rules and regulations
452 that authorize the health insurance issuer to perform its own

453 review to determine whether to continue the prior authorization
454 approval, and how the enrollee shall be affected if there is a
455 change in coverage or approval criteria.
456 (3) Except to the extent required by medical exceptions
457 processes for prescription drugs, nothing in this section shall
458 require a policy to cover any care, treatment, or services for any
459 health condition that the terms of coverage otherwise completely
460 exclude from the policy's covered benefits without regard for
461 whether the care, treatment, or services are medically necessary.
462 **SECTION 16.** **Effect of insurer's failure to comply.** A
463 failure by a health insurance issuer to comply with the deadlines
464 and other requirements specified in this act shall result in any
465 health care services subject to review to be automatically deemed
466 authorized by the health insurance issuer or its contracted
467 private review agent.
468 **SECTION 17.** **Enforcement and administration.** (1) In
469 addition to the enforcement powers granted to it by law to enforce
470 the provisions of this act, the department shall be authorized to
471 require a private review agent or health insurance issuer to
472 submit a plan of correction for violations of this act, or both.
473 Subject to regulations promulgated by the department, the
474 department may impose upon a private review agent, health benefit
475 plan or health insurance issuer an administrative fine not to
476 exceed Ten Thousand Dollars ($10,000.00) per violation for failure
477 to submit a requested plan of correction, failure to comply with

478 its plan of correction, or repeated violations of this act. The
479 department may also exercise all authority granted to it pursuant
480 to Section 41-83-13 to deny or revoke a certificate of a private
481 review agent for a violation of this act.

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

492 (3) The department shall promulgate rules and regulations
493 that require a health care provider or health care professional to
494 submit a plan of correction for fraud, waste or abuse in violation
495 of this act. Subject to regulations that the department shall
496 promulgate, the department may impose upon a health care provider
497 or health care professional an administrative fine not to exceed
498 Ten Thousand Dollars ($10,000.00) per violation for failure to
499 submit a requested plan of correction, failure to comply with its
500 plan of correction, or repeated violations of this act.

501 (4) Any person or his or her health insurance issuer, health
502 benefit plan or private review agent who believes that his or her

503 health care provider or health care professional is committing
504 fraud, waste or abuse in violation of this act may file a
505 complaint with the department. The department shall review all
506 complaints received and investigate all complaints that it deems
507 necessary to state a potential violation. The department shall
508 fairly, efficiently, and timely review and investigate complaints.
509 Health care providers or health care professionals found to be in
510 violation of this act shall be penalized in accordance with this
511 section.
512 (5) The department shall promulgate rules and regulations to
513 govern the administration of this section.
514 **SECTION 18.** **Reports to the department.** (1) By June 1,
515 2026, and each June 1 after that date, a health insurance issuer
516 shall report to the department, on a form issued by the
517 department, the following aggregated trend data related to the
518 insurer's prior authorization practices and experience for the
519 prior plan year:
520 (a) The number of prior authorization requests.
521 (b) The number of prior authorization requests denied.
522 (c) The number of appeals received.
523 (d) The number of adverse determinations reversed on
524 appeal.
525 (e) Of the total number of prior authorization
526 requests, the number of prior authorization requests that were not
527 submitted electronically.

528 (f) The ten (10) services that were most frequently
529 denied.
530 (g) The ten (10) reasons prior authorization requests
531 were most frequently denied.
532 (h) When legally permissible, the health care providers
533 and health care professionals who were issued a final
534 determination or adjudication of fraud, waste or abuse.
535 (2) All reports required by this section shall be considered
536 public records pursuant to the Mississippi Public Records Act of
537 1983, and the department shall make all reports freely available
538 to requestors and post all reports to its public website without
539 redactions.
540 **SECTION 19.** The department shall promulgate rules and
541 regulations that provide for the following:
542 (a) Creating a period of time for prior authorization
543 on inpatient stays at the hospitals that allows for the hospital
544 to access the correct insurance information of the patient. Such
545 time shall not be less than forty-eight (48) hours but not more
546 than five (5) days.
547 (b) Create a period of time for the re-authorization of
548 a change of procedure code where the health care provider or
549 health care professional was forced to make a change to the health
550 care service due to medical necessity that the prior authorization
551 was issued for and did not have sufficient time to request a new
552 prior authorization before the health care service had to be

553 performed. Such period of time shall not be more than fourteen
554 (14) days.

555 (c) Require an approved prior authorization form from a
556 third-party provider to contain at least the following information
557 when the form is returned to the enrollee, the enrollee's health
558 care professional and the enrollee's health care provider:

559 (i) The specific type of facility approved;

560 (ii) The specific facility approved; and

561 (iii) Whether the approval was for inpatient or
562 outpatient services.

563 **SECTION 20.** (1) The department shall promulgate any other
564 rules and regulations as necessary to effectuate the provisions of
565 this act. All rules and regulations shall be promulgated pursuant
566 to the Mississippi Administrative Procedures Act. Such rules and
567 regulations shall be promulgated not later than July 1, 2025.

568 (2) To the extent that any provision contained in this act
569 may conflict with any such applicable provision of law, regulation
570 or directive from the Centers for Medicare and Medicaid Services
571 with respect to the Division of Medicaid, the law, regulation or
572 directive from the Centers for Medicare and Medicaid Services
573 shall control. The Mississippi Division of Medicaid shall provide
574 notice to the Department of Insurance to any potential conflict,
575 and the Department of Insurance shall waive the conflicting
576 requirement created under this act. The Department of Insurance
577 shall notify the Chairmen of the House and Senate Insurance

578 Committees of any such waiver and provide public notice of the
579 waiver by posting the notice on their website. The Department of
580 Insurance shall promulgate any rules and regulations as necessary
581 on the implementation of the waiver process provided in this
582 subsection.

583 **SECTION 21.** Section 41-83-31, Mississippi Code of 1972, is
584 brought forward as follows:

585 41-83-31. Any program of utilization review with regard to
586 hospital, medical or other health care services provided in this
587 state shall comply with the following:

588 (a) No determination adverse to a patient or to any
589 affected health care provider shall be made on any question
590 relating to the necessity or justification for any form of
591 hospital, medical or other health care services without prior
592 evaluation and concurrence in the adverse determination by a
593 physician licensed to practice in Mississippi. The physician who
594 made the adverse determination shall discuss the reasons for any
595 adverse determination with the affected health care provider, if
596 the provider so requests. The physician shall comply with this
597 request within fourteen (14) calendar days of being notified of a
598 request. Adverse determination by a physician shall not be
599 grounds for any disciplinary action against the physician by the
600 State Board of Medical Licensure.

601 (b) Any determination regarding hospital, medical or
602 other health care services rendered or to be rendered to a patient

603 which may result in a denial of third-party reimbursement or a
604 denial of precertification for that service shall include the
605 evaluation, findings and concurrence of a physician trained in the
606 relevant specialty or subspecialty, if requested by the patient's
607 physician, to make a final determination that care rendered or to
608 be rendered was, is, or may be medically inappropriate.

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

616 **SECTION 22.** Section 83-9-6.3, Mississippi Code of 1972, is
617 brought forward as follows:

618 83-9-6.3. (1) As used in this section:

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

628 coordinated care organization program or health maintenance
629 organization program implemented by the Division of Medicaid.
630 (b) "Health insurance issuer" means any entity that
631 offers health insurance coverage through a health benefit plan,
632 policy, or certificate of insurance subject to state law that
633 regulates the business of insurance. "Health insurance issuer"
634 also includes a health maintenance organization, as defined and
635 regulated under Section 83-41-301 et seq., and includes the
636 Division of Medicaid for the services provided by fee-for-service
637 and through any managed care program, coordinated care program,
638 coordinated care organization program or health maintenance
639 organization program implemented by the division.
640 (c) "Prior authorization" means a utilization
641 management criterion used to seek permission or waiver of a drug
642 to be covered under a health benefit plan that provides
643 prescription drug benefits.
644 (d) "Prior authorization form" means a standardized,
645 uniform application developed by a health insurance issuer for the
646 purpose of obtaining prior authorization.
647 (2) Notwithstanding any other provision of law to the
648 contrary, in order to establish uniformity in the submission of
649 prior authorization forms, on or after January 1, 2014, a health
650 insurance issuer shall use only a single, standardized prior
651 authorization form for obtaining any prior authorization for
652 prescription drug benefits. The form shall not exceed two (2)

653 pages in length, excluding any instructions or guiding
654 documentation. The form shall also be made available
655 electronically, and the prescribing provider may submit the
656 completed form electronically to the health benefit plan.
657 Additionally, the health insurance issuer shall submit its prior
658 authorization forms to the Mississippi Department of Insurance to
659 be kept on file on or after January 1, 2014. A copy of any
660 subsequent replacements or modifications of a health insurance
661 issuer's prior authorization form shall be filed with the
662 Mississippi Department of Insurance within fifteen (15) days prior
663 to use or implementation of such replacements or modifications.
664 (3) A health insurance issuer shall respond within two (2)
665 business days upon receipt of a completed prior authorization
666 request from a prescribing provider that was submitted using the
667 standardized prior authorization form required by subsection (2)
668 of this section.
669 **SECTION 23.** This act shall take effect and be in force from
670 and after July 1, 2024.