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Chapter No. 508
13/HR12/R889SG
CST QAB

HOUSE BILL NO. 301

Originated in House  Clerk

HOUSE BILL NO. 301

AN ACT TO DIRECT HEALTH INSURANCE ISSUERS AND THE DIVISION OF MEDICAID TO USE A SINGLE, STANDARDIZED PRIOR AUTHORIZATION FORM FOR OBTAINING ANY PRIOR AUTHORIZATION FOR PRESCRIPTION DRUG BENEFITS; TO PROVIDE THAT A HEALTH INSURANCE ISSUER SHALL RESPOND WITHIN TWO BUSINESS DAYS UPON RECEIPT OF A COMPLETED PRIOR AUTHORIZATION REQUEST FROM A PRESCRIBING PROVIDER; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) As used in this section:

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

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

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

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

(2) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2014, a health insurance issuer shall use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation. The form shall also be made available

electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan. Additionally, the health insurance issuer shall submit its prior authorization forms to the Mississippi Department of Insurance to be kept on file on or after January 1, 2014. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Mississippi Department of Insurance within fifteen (15) days prior to use or implementation of such replacements or modifications.

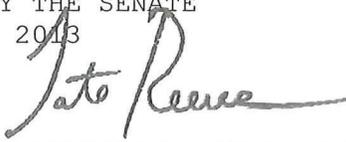
(3) A health insurance issuer shall respond within two (2) business days upon receipt of a completed prior authorization request from a prescribing provider that was submitted using the standardized prior authorization form required by subsection (2) of this section.

SECTION 2. This act shall take effect and be in force from and after July 1, 2013.

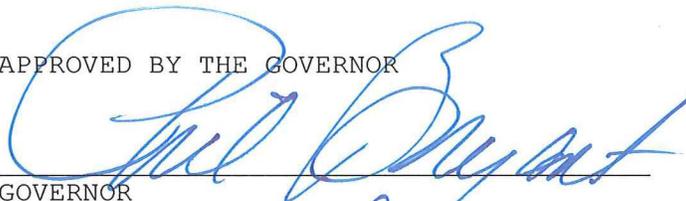
PASSED BY THE HOUSE OF REPRESENTATIVES
March 29, 2013


SPEAKER OF THE HOUSE OF REPRESENTATIVES

PASSED BY THE SENATE
April 2, 2013


PRESIDENT OF THE SENATE

APPROVED BY THE GOVERNOR


GOVERNOR

9:45 am
4-23-13